

# Issue Brief

FEDERAL ISSUE BRIEF

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July 17, 2025

## Proposed CY 2026 Hospital Outpatient and ASC PPS Update Released

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule to update policies and payment rates for services to hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2026 (CY 2026).

The 913-page rule is scheduled for publication in the **Federal Register** on July 17. The posted display copy is currently available at: <https://public-inspection.federalregister.gov/2025-13360.pdf>. Of course, this link will be superseded upon publication.

A 60-day comment period ending September 15 is provided.

The Addenda relating to the OPSS are available to download at:

<https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-p>

### Comments

CMS has provided a table of contents. We are providing such at the end of this analysis with corresponding page numbers in red. In addition, we are adding page numbers throughout this analysis.

There are many items in the rule not addressed in this summary and analysis.

Except for the payment and conversion factor updates, we are following, for the most part, the order of the rule. Below we are providing CMS' summary of the rule's major provisions.

Please note that there are several errors with regards to numbering in the table of contents with the text of the rule.

### PAYMENT UPDATES

#### **OPSS Update:** (Page 14)

For CY 2026, CMS proposes to increase the payment rates under the OPSS by an Outpatient Department (OPD) fee schedule increase factor of 2.4 percent. This increase factor is based on the proposed inpatient hospital market basket percentage increase of 3.2 percent reduced by a proposed productivity adjustment of 0.8 percentage point.

Based on this update, CMS estimates that total payments to OPSS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) for CY 2026 will be approximately \$100.0 billion, an increase of approximately \$8.1 billion compared to estimated CY 2025 OPSS payments.

CMS is continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPSS payments and copayments for all applicable services.

CMS notes that under the proposed 340B remedy offset, payments for services at hospitals subject to

the 340B remedy offset will be reduced by 2.0 percentage points. It is currently 0.5 percent.

**ASC Payment Update: (Page 15)**

CMS proposes to extend its utilization of the hospital market basket update as the update factor for the ASC payment system for 1 additional year (through CY 2026).

CMS proposes to increase payment rates under the ASC payment system by 2.4 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on the proposed hospital market basket percentage increase of 3.2 percent reduced by a proposed productivity adjustment of 0.8 percentage point.

Based on this proposed update, CMS estimates that total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2026 will be approximately \$9.2 billion, an increase of approximately \$480 million compared to estimated CY 2025 Medicare payments.

CMS estimates that total OPSS payments for CY 2026, including beneficiary cost-sharing, to the approximately 4,000 facilities paid under the OPSS (including general acute care hospitals, children’s hospitals, cancer hospitals, and CMHCs) would increase by approximately \$1.61 billion compared to CY 2025 payments due to the OPD update, excluding changes in enrollment, utilization, and case-mix.

For providers subject to the 340B remedy offset, the 340B remedy offset is estimated to reduce payments by \$1.1 billion in CY 2026.

**Proposed Conversion Factor Update (Page 85)**

To set the OPSS conversion factor for 2026, CMS proposes to increase the CY 2025 conversion factor of \$89.169 by 2.4 percent.

**Calculation of CY 2026 Proposed OPSS Conversion Factor**

|                 |   |
|-----------------|---|
| <i>Start:</i>   | CY 2025 Final OPSS Conversion Factor = <b>\$89.169</b>  |
| <i>Step 1a:</i> | Adjust the conversion factor to temporarily account for additional drug and device pass-through spending and outlier spending in CY 2025. This action causes an increase in the conversion factor. So, the amount of both drug and device pass-through spending (0.0037) and the percentage of outlier spending (0.01). as a share of total OPSS outpatient hospital spending is subtracted from 1.0000, which represents total OPSS outpatient hospital spending for CY 2025.<br>➤ $1.0000 - (0.0037 + 0.01) = 0.9863$ |
| <i>Step 1b:</i> | Divide \$89.169 by 0.9873<br>➤ $\$89.169 / 0.9863 = \$90.408$   |
| <i>Step 2:</i>  | Adjust the conversion factor by the required wage index budget neutrality adjustment of approximately 1.0116. This adjustment increases the amount of OPSS outpatient hospital spending and is multiplied with \$90.408.<br>➤ $\$90.408 * 1.0116 = \$91.456$  |
| <i>Step 3:</i>  | Adjust the conversion factor by the 5.0 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9995. This adjustment reduces the amount of outpatient hospital spending and is multiplied with \$91.456.<br>➤ $\$91.456 * 0.9995 = \$91.045$  |

|                 |   |
|-----------------|---|
| <i>Step 4:</i>  | Adjust the conversion factor by the cancer hospital payment adjustment of 1.0000. Because the PCR for cancer hospitals is the same between CY 2025 and CY 2026, there will be no change to the OPSS conversion factor.<br>➤ $\$91.045 \times 1.0000 = \$91.045$   |
| <i>Step 5:</i>  | Adjust the conversion factor by rural SCH adjustment policy of 1.0000. Since CMS is maintaining its current policy, there is no impact on the conversion by this policy.<br>➤ $\$91.045 \times 1.0000 = \$91.045$   |
| <i>Step 6a:</i> | Adjust the conversion factor by the OPD fee schedule increase factor of 0.024 for CY 2026. The OPD fee schedule increase factor increases outpatient hospital spending in CY 2026 over CY 2025 and is added to 1.0000 which represents total outpatient hospital OPSS spending in CY 2024.<br>➤ $1.0000 + 0.024 = 1.0240$   |
| <i>Step 6b:</i> | Multiply \$91.045 by 1.029<br>➤ $\$91.045 \times 1.024 = \$93.230$  |
| <i>Step 7a:</i> | Adjust the conversion factor to remove additional drug and device pass-through spending and outlier spending for CY 2026. This action causes a decrease in the conversion factor. So, the amount of both drug and device pass-through spending (0.0059) and the percentage of outlier spending (0.01) as a share of total OPSS outpatient hospital spending is subtracted from 1.0000, which represents total OPSS outpatient hospital spending for CY 2026.<br>➤ $1.0000 - (0.0059 + 0.01) = 0.9841$ |
| <i>Step 7b:</i> | Multiply \$90.408 by 0.9863 to get the CY 2026 OPSS conversion factor.<br>$\$93.23 \times 0.9841 = \mathbf{\$91.747}$   |
| <i>Finish:</i>  | <b>CY 2024 OPSS Conversion Factor = \$91.747</b>  |
| <i>Step 8:</i>  | Multiply \$91.747 by 0.9805 to get the CY 2026 proposed OPSS conversion factor for providers subject to the 340B remedy offset.<br>$\$91.747 \times 0.9805 = \mathbf{\$89.958}$   |

### Comment

Note: We have changed the title of the calculation of the CY 2026 conversion factor. CMS said it was "final." We believe it is "proposed", as noted in step 8 above.

### Proposed Wage Index Changes (Page 92)

The OPSS labor-related share remains at 60 percent of the national OPSS payment.

CMS will standardize 60 percent of estimated claims costs for geographic area wage variation using the same FY 2026 pre-reclassified wage index that it uses under the IPPS to standardize costs.

Frontier State hospitals would receive a wage index of 1.00 if the otherwise applicable wage index (including reclassification, the rural floor, and rural floor budget neutrality) is less than 1.00. (Page 93)

Consistent with the FY 2026 IPPS/LTCH PPS proposed rule, CMS proposes to discontinue for CY 2026 and subsequent years the low wage index hospital policy under the OPSS. (Page 95)

If a hospital is significantly impacted by the discontinuation of the low wage index hospital policy, meaning the hospital's proposed CY 2026 wage index is decreasing by more than 9.75 percent from the hospital's CY 2024 wage index, then the transitional payment exception for CY 2026 for that hospital would be equal to the additional CY 2026 amount the hospital would be paid under the OPSS if its CY 2026 wage index were equal to 90.25 percent of its CY 2024 wage index. (Page 98)

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Addendum L may be downloaded through the “2026 NPRM OPPS Addenda under related links at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-p>

## **I. SUMMARIES of SELECT PROVISIONS (Page 12)**

The following are brief summaries of select items from the regulation’s preamble text.

### ***Device Pass-Through Payment Applications: (Page 15)***

For CY 2026, CMS received 7 complete applications for device pass-through payments. CMS will make final determinations on these applications in the CY 2026 OPPS/ASC final rule.

### ***Changes to the List of ASC Covered Surgical Procedures and Ancillary Services Lists: (Page 16)***

For CY 2026, CMS proposes to expand the ASC Covered Procedures List (CPL) by revising the criteria under § 416.166 to modify the general standard criteria and to eliminate five of the general exclusion criteria, moving them into a new section as nonbinding physician considerations for patient safety.

CMS also proposes to add 276 procedures to the ASC CPL based on these criteria changes and add an additional 271 codes to the ASC CPL that are proposed for removal from the Inpatient Only (IPO) list for CY 2026.

### ***Changes to the Inpatient Only (IPO) List: (Page 16)***

For CY 2026, CMS proposes to phase out the IPO list over 3 years, beginning with the removal of 285 mostly musculoskeletal services for CY 2026.

### ***Add-on Payment for Radiopharmaceutical Technetium-99m (Tc-99m) Derived from Domestically Produced Molybdenum-99 (Mo-99): (Page 16)***

For CY 2026, CMS proposes a \$10 per dose amount for the Mo-99 add-on payment, and that at least 50 percent of the Mo-99 used in the Tc-99m generator that produces a dose of Tc-99m must be domestically produced for the dose to qualify for the add-on payment.

CMS also proposes to codify its definition for domestically produced Mo-99, and to establish new HCPCS C-code C917X (Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose).

### ***Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs: (Page 16)***

CMS proposes to remove: (1) the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the Hospital OQR and ASCQR Program measure sets beginning with the CY 2024 reporting period/CY 2026 payment determination; (2) the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Program measure sets and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program measure set beginning with the CY 2025 reporting period/CY 2027 payment or program determination; and (3) the Screening for Social Drivers of Health (SDOH) measure and the Screen Positive Rate for SDOH measure from the Hospital OQR, REHQR, and ASCQR Program measure sets beginning with the CY 2025 reporting period.

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CMS also proposes to update and codify the Extraordinary Circumstance Exception (ECE) policy to clarify that CMS has the discretion to grant an extension in response to an ECE request for the Hospital OQR, REHQR, and ASCQR Programs.

***Hospital Outpatient Quality Reporting (OQR) Program: (Page 17)***

CMS proposes to: (1) adopt the Emergency Care Access & Timeliness eCQM with one year of voluntary reporting for the CY 2027 reporting period followed by mandatory reporting for the CY 2028 reporting period/CY 2030 payment determination and subsequent years; (2) remove the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients and the Left Without Being Seen measures beginning with the CY 2028 reporting period/2030 payment determination; and (3) modify the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Outpatient) measure (Excessive Radiation eCQM) from mandatory reporting beginning with the CY 2027 reporting period to continue voluntary reporting in the CY 2027 reporting period and subsequent years.

***Rural Emergency Hospital Quality Reporting (REHQR) Program: (Page 17)***

CMS proposes to: (1) adopt the Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination; and (2) establish related eCQM data submission and reporting requirements, including that REHs would be provided the option of reporting either the Emergency Care Access and Timeliness eCQM or the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure beginning with the CY 2027 reporting period/CY 2029 program determination.

***Ambulatory Surgical Center Quality Reporting (ASCQR) Program: (Page 18)***

CMS proposes to: (1) adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination.

***Overall Hospital Quality Star Rating Modification to Emphasize the Safety of Care Measure Group: (Page 18)***

CMS is proposing to update the methodology that will be used to calculate the Overall Hospital Quality Star Rating through implementation of a 2-stage methodologic update.

CMS is updating the methodology to emphasize the importance of the Safety of Care measure group, particularly to address the issue of hospitals receiving a high Star Rating despite performing in the lowest quartile of the Safety of Care measure group.

***Partial Hospitalization and Intensive Outpatient: (Page 19)***

CMS proposes to calculate the CY 2026 Community Mental Health Center (CMHC) Partial Hospitalization Program (PHP), and Intensive Outpatient Program (IOP) costs based on 40 percent of the corresponding proposed hospital-based PHP and IOP costs. CMS says this change would resolve a cost inversion in CMHC cost data that resulted in higher geometric mean costs for 3-service days than for 4-service days.

***Notice of Intent to Conduct a Medicare OPDS Drugs Acquisition Cost Survey: (Page 19)***

CMS will be conducting a survey, with the survey submission window opening by early CY 2026, of the

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acquisition costs for each separately payable drug acquired by all hospitals paid under the OPSS.

***Two Midnight Rule Medical Review Activities Exemptions:*** (Page 19)

CMS proposes to continue its existing policy exempting procedures that are removed from the inpatient only (IPO) list under the OPSS from certain medical review activities related to the two-midnight policy.

***Virtual Direct Supervision of Pulmonary Rehabilitation (PR), Coronary Rehabilitation (CR), Intensive Coronary Rehabilitation and Diagnostic Services:*** (Page 20)

CMS proposes to revise § 410.27(a)(1)(iv)(B)(1) and § 410.28(e)(2)(iii) to make the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) permanent, except for diagnostic services that have a global period indicator of 010 or 090.

***Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy:*** (Page 20)

For CY 2026, CMS proposes to revise the reduction to the OPSS conversion factor under § 419.32(b)(1)(iv)(B)(12) used to determine the payment amounts for non-drug items and services for hospitals for whom this adjustment applies from 0.5 percent to 2.0 percent.

The Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 codified a 0.5 percent reduction in the OPSS conversion factor applicable to non-drug items and services, excluding hospitals that enrolled in Medicare after January 1, 2018. This 0.5 percent reduction would remain in effect until the estimated payment reduction reached the estimated \$7.8 billion of increased non-drug item and services payments made from CY 2018 through CY 2022, which CMS estimated would occur in CY 2041.

This prospective offset is aimed to balance the goal of restoring hospitals to their financial position had the original 340B policy never existed, while avoiding burdening them with an immediate single year recovery. After subsequent reconsideration of balancing these two goals, CMS has determined a shorter timeframe to be more appropriate. This proposed 2.0 percent reduction would remain in effect for certain hospitals until the estimated payment reduction reaches \$7.8 billion, which CMS estimates will occur in CY 2031.

***Payment for Skin Substitute Products under the OPSS:*** (Page 21)

CMS proposes to group skin substitutes that are not drugs or biologicals using three FDA regulatory categories (PMAs, 510(k)s, and 361 HCT/Ps) to set payment rates.

CMS proposes to create three new APCs for HCPCS codes that describe skin substitute products organized by clinical and resource similarity. Specifically, CMS proposes to create: APC 6000 (PMA Skin Substitute Products); APC 6001 (510(k) Skin Substitute Products); and APC 6002 (361 HCT/P Skin Substitute Products).

This proposal would result in an initial payment rate of \$125.38 for each of the new proposed APCs. CMS would implement this policy in both the non-facility, ambulatory surgical center setting, and outpatient hospital settings.

***Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs):*** (Page 21)

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For CY 2026, CMS proposes to use its authority under section 1833(t)(2)(F) of the Act to apply the Physician Fee Schedule equivalent rate for any HPCPCs codes assigned to the drug administration services APCs, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act. CMS proposes to exempt rural Sole Community Hospitals from this method.

***Request for information on Adjusting Payment under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings:*** (Page 21)

CMS is requesting information for future rulemaking on the development of a systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and adjusting payments accordingly.

***Request for information on Software as a Service:*** (Page 22)

CMS is issuing a request for information on alternative and consistent payment methods for software as a service (SaaS) under the OPPS to consider for future rulemaking.

***Proposed Market-Based MS–DRG Relative Weight Data Collection and Change in Methodology for Calculating MS–DRG Relative Weights Under the Inpatient Prospective Payment System:*** (Page 22)

In order to reduce the Medicare program’s reliance on the hospital chargemaster, and to support the development of a market-based approach to payment under the Medicare FFS system, CMS proposes that hospitals would be required to report certain market-based payment rate information on their Medicare cost report for cost reporting periods ending on or after January 1, 2026, to be used in a proposed change to the methodology for calculating the IPPS MS–DRG relative weights to reflect relative market-based pricing.

Specifically, the market-based rate information CMS proposes to collect on the Medicare cost report would be the median of the payer-specific negotiated charges by MS–DRG, for a hospital’s MA organizations (MAOs).

CMS also proposes a change to the methodology for calculating the IPPS MS–DRG relative weights to incorporate this market-based rate information, beginning in FY 2029. This proposed MS–DRG relative weight methodology would utilize the proposed median payer-specific negotiated charge information, collected on the cost report, for calculating the MS–DRG relative weights.

***Graduate Medical Education (GME) Accreditation:*** (Page 23)

CMS proposes that accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place, diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of Federal law.

The effective date of this proposal would be January 1, 2026.

***Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges:*** (Page 21)

CMS proposes amendments to the hospital price transparency (HPT) regulations to enhance clarity and standardization in hospital pricing disclosures. Specifically, CMS proposes revisions to § 180.20 to add definitions for “tenth (10th) percentile allowed amount,” “median allowed amount,” and “ninetieth (90th) percentile allowed amount,” to more accurately reflect the distribution of actual amounts that the hospital has received for an item or service.

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CMS proposes revisions to § 180.50 to remove the requirement for hospitals to encode the estimated allowed amount and instead require hospitals, beginning January 1, 2026, to disclose the 10th percentile, median, and 90th percentile allowed amounts in machine-readable files (MRFs) when standard charges are based on percentages or algorithms, as well as the count of allowed amounts.

CMS also proposes that hospitals should use EDI 835 transaction remittance advice (ERA) transaction data to calculate and encode these values, and CMS proposes specific instructions to hospitals with regard to the methodology, including lookback period, that should be used to calculate these amounts.

CMS proposes revisions to § 180.50(a)(3) to update the attestation language hospitals must include in the MRF and to require hospitals to encode the name of the chief executive officer, president or senior hospital official designated to oversee the encoding of true, accurate, and complete data in the MRF. CMS proposes revisions to § 180.50(b)(2)(i)(A) to require hospitals, beginning January 1, 2026, to encode in a newly created general data element in the MRF their Type 2 (organizational) National Provider Identifier(s) (NPI).

## II. UPDATES AFFECTING OPPTS PAYMENTS

### Calculation of Single Procedure APC Criteria-Based Costs (Page 35)

#### (1) *Blood and Blood Products* (Page 39)

CMS will continue to establish payment rates for blood and blood products using its blood-specific cost-to-charge ratio (CCR) methodology. Addendum B contains the CY 2026 payment rates for blood and blood products and can be downloaded using the "2026 NPRM OPPTS Addenda" link under related links at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice/cms-1834-p>

#### (2) *Brachytherapy Sources* (Page 46)

CMS will continue to use its equitable adjustment authority under section 1833(t)(2)(E) of the Act to maintain the CY 2024 payment rate of \$4.69 per mm<sup>2</sup> for HCPCS code C2645, which is to be assigned to APC 2648 (Brachytx planar, p-103) for CY 2026.

For CY 2026 and subsequent years, CMS proposes to pay for the stranded and Non-stranded not otherwise specified (NOS) codes, HCPCS codes C2698 (Brachytherapy source, stranded, not otherwise specified, per source) and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source), at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per-source basis.

The proposed CY 2026 payment rates for brachytherapy sources are included in Addendum B that can be downloaded using the "2026 NPRM OPPTS Addenda" under related links at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice/cms-1834-p>

For CY 2026, CMS proposes to designate six brachytherapy APCs as Low Volume APCs as these APCs meet CMS' criteria to be designated as Low Volume APCs.

### Comprehensive APCs (C-APCs) (Page 45)

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A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. The number of C-APCs now total 72.

A list of services excluded from the C-APC policy is included in Addendum J and available for download under related links "2026 NPRM OPPS Addenda" at:  
<https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice/cms-1834-p> (Page 46)

If a service does not appear on this list of excluded services, payment for it will be packaged into the payment for the primary C-APC service when it appears on an outpatient claim with a primary C-APC service. (Page 47)

CMS is not proposing to convert any standard APCs to C-APCs in CY 2026; thus, CMS proposes that the number of C-APCs for CY 2026 would be the same as the number for CY 2025. (Page 61)

The proposal's table 2 contains the list of the 72 C-APCs. (Page 62)

#### Calculation of Composite APC Criteria-Based Costs (Page 63)

- *Mental Health Services Composite APC (Page 64)*

For CY 2026, CMS proposes to continue its longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment for a day of partial hospitalization services provided by a hospital, which the agency considers to be the most resource-intensive of all outpatient mental health services.

- *Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008) (Page 66)*

The rule's Table 3 lists the HCPCS codes that would be subject to the multiple imaging composite APC policy and their respective families and approximate composite APC geometric mean costs for CY 2026. (Page 68)

- *Payment for Diagnostic Radiopharmaceuticals (Page 77)*

CMS is updating the CY 2025 package payment threshold of \$630 for diagnostic radiopharmaceuticals to \$655.

The proposed list of diagnostic radiopharmaceuticals that CMS has calculated as having per day costs that exceed \$655 and their proposed status indicators can be found in Table 4.

(Page 81)

#### ***Proposed Adjustment for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) under Section 1833(t)(13)(B) of the Act for CY 2026:***

(Page 103)

For CY 2026, CMS proposes to continue the current policy of a 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, items paid at charges reduced to costs, and devices paid under the pass-through payment policy, applied in a budget neutral manner.

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**Proposed Payment Adjustment for Certain Cancer Hospitals for CY 2026:** (Page 104)

CMS would apply a target PCR of 0.87 to the 11 specified cancer hospitals for CY 2026. (Page 109)

The rule's Table 7 shows the estimated percentage increase in OPSS payments to each cancer hospital for CY 2026. (Page 109)

**Proposed Hospital Outpatient Outlier Payments:** (Page 110)

Using CY 2024 claims data and CY 2025 payment rates, CMS estimates that the aggregate outlier payments for CY 2025 would be approximately 0.92 percent of the total CY 2025 OPSS payments. CMS will continue its policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPSS. CMS notes that a portion of that 1.0 percent, an amount equal to less than 0.01 percent of outlier payments (or 0.0001 percent of total OPSS payments), would be allocated to CMHCs for partial hospitalization program (PHP) and intensive outpatient program (IOP) outlier payments.

To ensure that the estimated CY 2026 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPSS, CMS proposes that the hospital outlier threshold be set so that outlier payments would be triggered when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment amount plus the fixed-dollar threshold.

**Proposed Calculation of an Adjusted Medicare Payment from the National Unadjusted Medicare Payment:** (Page 114)

The national unadjusted payment rate is the payment rate for most APCs before accounting for the wage index adjustment or any applicable adjustments.

The national unadjusted payment rate for most APCs contained in Addendum A and available for download under related links "2026 NPRM OPSS Addenda" at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-p> and for most HCPCS codes to which separate payment under the OPSS has been assigned in Addendum B to this proposed rule is calculated by multiplying the proposed CY 2026 scaled weight for the APC by the CY 2026 conversion factor.

**III. PROPOSED OPSS AMBULATORY PAYMENT CLASSIFICATION (APC) GROUP POLICIES** (Page 129)

**A. Proposed OPSS Treatment of New and Revised HCPCS Codes**

CMS recognizes the following codes on OPSS claims:

- Category I CPT codes, which describe surgical procedures, diagnostic and therapeutic services, and vaccine codes;
- Category III CPT codes, which describe new and emerging technologies, services, and procedures;
- MAAA CPT codes, which describe laboratory multianalyte assays with algorithmic analyses (MAA);
- PLA CPT codes, which describe proprietary laboratory analyses (PLA) services; and
- Level II HCPCS codes (also known as alpha-numeric codes), which are used primarily to identify drugs, devices, supplies, temporary procedures, and services not described by CPT codes.

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The following reflects CMS' treatment of new codes added during the year.

1. *April 2025 HCPCS Codes*

For the April 2025 update, 104 new HCPCS codes were established and made effective on April 1, 2025. These codes and their long descriptors are listed in the rules' Table 9. (Page 132)

2. *July 2025 HCPCS Codes*

For the July 2025 update, 110 new codes were established and made effective July 1, 2025. The codes and long descriptors are listed in the rule's Table 10. (Page 135)

3. *October 2025 HCPCS Codes* (Page 140)

CMS will solicit comments on the new CPT and Level II HCPCS codes that will be effective October 1, 2025, in the CY 2026 OPPS/ASC final rule.

4. *January 2026 HCPCS Codes* (Page 140)

CMS will solicit comments on the new Level II HCPCS codes that will be effective January 1, 2026 in the CY 2026 OPPS/ASC final rule.

**B. OPPS Changes – Variations within APCs:** (Page 143)

The Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost for an item or service in the group is more than 2 times greater than the lowest cost for an item or service within the same group (referred to as the "2 times rule"). The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low volume items and services.

Based on the updated final rule CY 2024 claims data used for this CY 2026 proposed rule CMS found a total of 26 APCs with violations of the 2 times rule.

The rule's Table 12 lists the 26 APCs that are being excepted from the 2 times rule for CY 2026. (Page 148)

**C. New Technology APCs** (Page 148)

Procedures Assigned to New Technology APC Groups for CY 2026

- a. Administration of Subretinal Therapies Requiring Vitrectomy (APC 1563) (Page 154)
- b. BgRT (APC 1514 and 1525) (Page 158)
- c. Blinded procedure for NYHA class III/IV heart failure (Page 160)
- d. Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy (Page 162)
- e. Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies (APCs 1520 and 1522) (Page 163)
- f. CardiAMP (APC 1590) (Page 165)
- g. Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) (APC 1511) (Page 167)
- h. Corvia Medical Interatrial Shunt Procedure (APC 1592) (Page 171)
- i. DARI Motion Procedure (APC 1505) (Page 173)
- j. Instillation of Anti-Neoplastic Pharmacologic/Biologic Agent into Renal Pelvis (APC 1558) (Page 174)
- k. LimFlow TADV procedure CPT Code 0620T (APC 1579) (Page 175)
- l. Liver Histotripsy Service (APC 1576) (Page 177)

- m. Liver Multiscan Service (APC 1511) (Page 179)
- n. Optellum Lung Cancer Prediction (LCP) (APC 1508) (Page 182)
- o. Quantitative Magnetic Resonance (QMR) for analysis of tissue composition (APC 1511) (Page 184)
- p. Quantitative Magnetic Resonance Cholangiopancreatography (QMRCPC) (APC 1511) (Page 187)
- q. Scalp Cooling (APC 1519) (Page 188)
- r. Supervised Visits for Esketamine Self-Administration (APCs 1513 and 1518) (Page 191)
- s. Surfacor® Inside-Out® Access Catheter System (APC 1534) (Page 193)
- t. TASS (APC 1537) (Page 194)
- u. Magnetic Resonance Imaging with Inhaled Hyperpolarized Xenon-129 contrast agent (APC 1551) (Page 196)
- v. SAINT Neuromodulation System (Page 197)
- w. Implantable Glucose Monitoring System (APC 1561) (Page 200)
- x. Skin Cell Suspension Autograft (SCSA) Procedures (CPT Code 15013 and HCPCS code C8002) (APC 1567) (Page 202)
- y. Renal Histotripsy Service (APC 1576) (Page 203)

**D. Universal Low Volume APC Policy for Clinical and Brachytherapy APCs (Page 205)**

Based on claims data available for the CY 2025 OPPS/ASC rule, CMS is designating six brachytherapy APCs and five clinical APCs as low volume APCs under the OPPS.

The rule's Table 39 lists these 11 APCs. (Page 206)

**E. APC-Specific Policies: (Page 207)**

CMS is addressing the following specific APC items.

1. Neurostimulator and Related Procedures (APCs 5461 Through 5465) (Page 207)
2. APC Structure (Page 207)
3. Musculoskeletal Procedures (APCs 5111 through 5117) (Page 209)
4. Fractional Flow Reserve Derived From Computed Tomography (FFRct), CPT Code 75580 (APC 5724) (Page 211)

**F. Comment Solicitation on Payment Policy for Software as a Service (SaaS) (Page 214)**

In recent years, there have been rapid developments in the use of software-based technologies to support clinical decision-making in the outpatient and physician office settings. Medicare refers to these software-based technologies as software as a service (SaaS). CMS currently does not have a comprehensive Medicare payment policy specific to SaaS that accounts for the unique challenges of paying for these services.

For CY 2026, CMS is soliciting comments from the public on payment policies for these services under the OPPS, including applicable lessons learned from risk-bearing payment arrangements and input that helps incorporate the underlying value of technologies within medical practice into payment policy. CMS notes the agency is similarly seeking comment on this issue under the CY 2026 PFS proposed rule.

**G. Continuation of Payment Policy for Radiation Therapy Services Furnished at Nonexcepted Off-Campus Provider Based Departments (PBDs) (Page 216)**

As a general matter, under sections 1833(t)(1)(B)(v) and (t)(21) of the Act, applicable items and services furnished by certain off-campus outpatient departments of a provider on or after January 1,

2017, are not considered covered OPD services as defined under section 1833(t)(1)(B) of the Act for purposes of payment under the OPPS. Instead such items are paid “under the applicable payment system” under Medicare Part B if the requirements for such payment are otherwise met.

As discussed in the CY 2026 Physician Fee Schedule (PFS) proposed rule, CMS proposed to delete radiation therapy G-codes (G6001 – G6017) that describe imaging guidance for radiation treatment (G6001, G6002, G6017) and radiation treatment delivery (G6003-G6015) because CPT codes 77402, 77407, and 77412 have been revised and may be used to report these services instead.

Refer Table 44 (Page 240) for the long descriptors of the G codes that will be deleted effective January 1, 2026 and Table 45 (Page 221) for the current and revised long descriptors for CPT codes 77402, 77407, and 77412. The proposed CY 2026 payment rates for the radiation treatment delivery codes can be found in Addendum B.

#### IV. OPPS PAYMENT for DEVICES (Page 221)

##### A. Pass-Through Payment for Devices

Currently, there are 17 device categories eligible for pass-through payment. These devices are listed in Table 46 (below) where CMS details the expiration dates of pass-through payment status for each of the 17 devices currently receiving device pass-through payment.

**Table 46: Devices with Pass-Through Status Expiring in 2025, In 2026, or in 2027**

| HCPCS Code | Long Descriptor   | Effective Date | Pass-Through Expiration Date |
|------------|---|----------------|------------------------------|
| C1826      | Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system         | 01/1/2023      | 12/31/2025                   |
| C1827      | Generator, neurostimulator (implantable), non- rechargeable, with implantable stimulation lead and external paired stimulation controller                           | 01/01/2023     | 12/31/2025                   |
| C1747      | Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)  | 01/01/2023     | 12/31/2025                   |
| C1600      | Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)   | 01/01/2024     | 12/31/2026                   |
| C1601      | Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)  | 01/01/2024     | 12/31/2026                   |
| C1602      | Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)  | 01/01/2024     | 12/31/2026                   |
| C1603      | Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)  | 01/01/2024     | 12/31/2026                   |
| C1604      | Graft, transmural transvenous arterial bypass (implantable), with all delivery system components  | 01/01/2024     | 12/31/2026                   |
| C1605      | Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation | 07/01/2024     | 06/30/2027                   |
| C1606      | Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope  | 07/01/2024     | 06/30/2027                   |
| C8000      | Support device, extravascular, for arteriovenous fistula (implantable)  | 10/01/2024     | 9/30/2027                    |
| C1735      | Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components  | 01/01/2025     | 12/31/2027                   |
| C1736      | Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components  | 01/01/2025     | 12/31/2027                   |

|       |   |            |            |
|-------|---|------------|------------|
| C1737 | Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable) | 01/01/2025 | 12/31/2027 |
| C1738 | Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device                          | 01/01/2025 | 12/31/2027 |
| C1739 | Tissue marker, probe detectable any method (implantable), with delivery system                            | 01/01/2025 | 12/31/2027 |
| C9610 | Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)        | 01/01/2025 | 12/31/2025 |

### **New Device Pass-Through Applications for CY 2026 (Page 224)**

CMS received eight complete applications by the March 3, 2025, quarterly deadline, which was the last quarterly deadline for applications to be received in time to be included in this proposed rule. (Page 228)

One application was withdrawn. Two of the applications were approved for device pass-through payment during the quarterly review process: VasQ, which was preliminarily approved upon quarterly review under the alternative pathway effective July 1, 2024, and the SCOUT MD™ Surgical Guidance System which was preliminarily approved upon quarterly review under the alternative pathway effective September 1, 2024. All applications that are preliminarily approved upon quarterly review will automatically be included in the next applicable OPPS annual rulemaking cycle.

They 7 remaining are as follows:

#### **(1) Alternative Pathway Device Pass-Through Applications**

- (a) aprevo® Cervical ACDF system, aprevo® Cervical ACDF-X system, aprevo® Cervical ACDF-X NO CAM system (Page 229)
- (b) FARAPULSE™ Pulsed Field Ablation (PFA) System (Page 237)
- (c) SCOUT MD™ Surgical Guidance System (Page 244)
- (d) VasQ™ (Page 250)

#### **(2) Traditional Device Pass-Through Applications**

- (a) Axoguard HA+ Nerve Protector™ (Page 255)
- (b) LithoVue™ Elite Digital Flexible Ureteroscope System with Pressure Monitoring (Page 267)
- (c) VersaVue™ Single-Use Flexible Cystoscope (Page 283)

### **Device-Intensive Procedures (Page 299)**

The full listing of the proposed CY 2026 device-intensive procedures can be found in Addendum P at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient>.

## **V. OPPS PAYMENT FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS (Page 313)**

### **A. Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals**

#### **1. Drugs and Biologicals with Expiring Pass-Through Payment Status in CY 2024 (Page 313)**

There are 28 drugs and biologicals for which pass-through payment status expires by December 31, 2025, as listed in the rule's Table 57. (Page 317)

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*2. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Expiring in CY 2026. (Page 318)*

CMS proposes to end pass-through payment status in CY 2026 for 52 drugs and biologicals. These drugs and biologicals, which were initially approved for pass-through payment status between April 1, 2023 and January 1, 2024, are listed in Table 57. (Page 321)

*3. Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Payment Status Continuing through CY 2026. (Page 324)*

CMS will continue pass-through payment status in CY 2026 for 41 drugs and biologicals. These drugs and biologicals, which were approved for pass-through payment status with effective dates beginning between April 1, 2024, and April 1, 2025, are listed in the rule's Table 58. (Page 327)

***B. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status (Page 329)***

*1. Packaging Threshold*

CMS proposes a packaging threshold for CY 2026 of **\$140** for drugs, biologicals, and therapeutic Radiopharmaceuticals, the same as the current threshold.

*2. Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Certain Biologicals, and Certain Therapeutic Radiopharmaceuticals Under the Cost Threshold ("Threshold-Packaged Drugs.") (Page 332)*

For CY 2026, CMS proposes to use payment rates based on the ASP data from the fourth quarter of CY 2024 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B.

*3. Packaging Determination for HCPCS Codes that Describe the Same Drug or Biological but Different Dosages. (Page 337)*

CMS proposes to continue its policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2026.

The packaging status of each drug and biological HCPCS code to which this methodology will apply in CY 2026 is displayed in the rule's Table 60. (Page 339)

***Biosimilar Biological Products (Page 345)***

The ***Inflation Reduction Act of 2022*** (IRA) requires a temporary increase in the add-on payment for qualifying biosimilar biological products from 6 percent to 8 percent of the ASP of the reference biological beginning October 1, 2022. This increase applies for a 5-year period.

For a qualifying biosimilar for which payment is first made using ASP during the period beginning October 1, 2022, and ending December 31, 2027, the statute defines the applicable 5-year period as the 5-year period beginning on the first day of such calendar quarter of such payment. These payment rates are published in the quarterly release of Addendum B or ASP pricing files. (Page 346)

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### **Invoice Drug Pricing for CY 2026 (Page 346)**

CMS proposes to clarify that CMS will determine whether the first condition is met, whether the drug is not policy packaged; however, the MAC will continue to determine whether the second condition is met, whether the per-day cost of the drug, biological, therapeutic radiopharmaceutical or diagnostic radiopharmaceutical is above threshold packaging amount, as applicable.

### **Payment for Blood Clotting Factors (Page 350)**

For CY 2026, CMS will continue its established policy to provide payment for blood clotting factors using the same methodology as other separately payable drugs and biologicals under the OPSS and to continue to pay a furnishing fee.

### **Requirement in the CY 2026 Physician Proposed Fee Schedule for HOPDs and ASCs to Report Discarded Amounts of Certain Single-dose or Single-use Package Drugs (Page 351)**

Section 90004 of the **Infrastructure Investment and Jobs Act** (“the Infrastructure Act”) amended section 1847A of the Act to require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug.

### **Remedy Payment Adjustment for 340B-Acquired Drugs from CY 2018 Through September 27, 2022 (Page 357)**

Effective January 1, 2026, CMS proposes to revise the annual reduction to the OPSS conversion factor under § 419.32(b)(1)(iv)(B)(12) used to determine the payment amounts for non-drug items and services from 0.5 percent to 2.0 percent. Under this revised rate, CMS expects it would take approximately 6 years to reach the total offset of \$7.8 billion. Consistent with the Final Remedy rule, this reduction would not apply to new providers.

### **Payment for Skin Substitutes (Page 372)**

Skin substitutes assigned to the high-cost group are described by HCPCS codes 15271 through 15278. Skin substitutes assigned to the low-cost group are described by HCPCS codes C5271 through C5278.

CMS proposes, starting January 1, 2026, to separately pay for the provision of certain groups of skin substitute products as incident-to supplies when, for those products that are coverable under Medicare’s rules, they are used during a covered application procedure paid under the PFS in the non-facility setting or under the OPSS.

CMS refers readers to Addendum B for the APC assignments and associated payment rates for HCPCS codes 15271 through 15278. CMS also proposes to combine the existing claims data available for the two sets of current OPSS codes, the low-cost and the high-cost administration groups, to set the initial payment rate for the proposed skin substitute administration procedures described by HCPCS codes 15271 through 15278. CMS proposes to establish initial payment rates for the three FDA regulatory categories based on the volume-weighted average ASP, with no additional markup, for skin substitute products in each category as submitted by manufacturers, when available. CMS has developed initial payment rates for each group based on the weighted, per-unit average of ASPs for the fourth quarter of calendar year 2024. These initial payment rates are listed in the file titled “Skin Substitute Products by FDA Regulatory Category” on the CMS website at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

### **Comment**

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See CMS' summary section starting on page 403 for more details.

***CY 2026 Physician Fee Schedule Proposal Regarding Cell and Gene Therapies*** (Page 405)

In the CY 2026 PFS proposed rule, CMS proposed that (1) preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy be included in the payment of the product itself and (2) that, beginning January 1, 2026, any preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy that were paid for by the manufacturer be included in the calculation of the manufacturer's ASP.

***Add-on Payment for Technetium-99m (Tc-99m) Derived from Domestically Produced Molybdenum-99 (Mo-99)*** (Page 407)

In the CY 2025 OPPTS/ASC final rule, CMS finalized its proposal to address the payment inequity resulting from the higher cost of Tc-99m derived from domestically produced Mo-99 by establishing a new add-on payment of \$10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 starting on January 1, 2026.

**VI. ESTIMATE OF OPPTS TRANSITIONAL PASS-THROUGH SPENDING FOR DRUGS, BIOLOGICALS, RADIOPHARMACEUTICALS, AND DEVICES** (Page 417)

CMS estimates that the amount of pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2026 and the amount of pass-through spending for those device categories, drugs, and biologicals that first become eligible for pass-through payment during CY 2026 would be approximately \$587.0 million (approximately \$571.8 million for device categories and approximately \$15.2 million for drugs and biologicals), which represents only 0.59 percent of total projected OPPTS payments for CY 2026 (approximately \$100 billion). Therefore, pass-through spending in CY 2026 will not exceed the 2.0 percent of total projected OPPTS CY 2026 program spending limit provided for in section 1833(t)(6)(E) of the Act.

**VII. OPPTS PAYMENT FOR HOSPITAL OUTPATIENT VISITS AND CRITICAL CARE SERVICES** (Page 424)

CMS will continue to utilize the Physician Fee Schedule (PFS)-equivalent payment rate for hospital outpatient clinic visit services described by HCPCS code G0463 when it is furnished by excepted off-campus provider-based departments. The PFS-equivalent rate for CY 2026 would be 40 percent of the OPPTS payment.

**VIII. PAYMENT FOR PARTIAL HOSPITALIZATION SERVICES AND INTENSIVE OUTPATIENT SERVICES** (Page 425)

A partial hospitalization program (PHP) is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders.

An intensive outpatient program (IOP) is a distinct and organized program of psychiatric services for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and SUD. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization.

**Coding and Billing for PHP and IOP Services under the OPPS (Page 433)**

Beginning January 1, 2024, CMS required the use of condition code 41 on all PHP claims from hospitals and CMHCs and required the use of condition code 92 on all IOP claims from hospitals and CMHCs.

**Proposed CY 2026 Payment Rates for PHP and IOP (Page 435)**

Table 68 summarizes the PHP and IOP geometric costs calculated using the current methodology.

**Table 68: Proposed CY 2026 PHP And IOP APC Geometric Mean Per Diem Costs**

| CY 2026 APC | Group Title  | PHP and IOP APC Geometric Mean Per Diem Costs |
|-------------|--|---|
| 5851        | Intensive Outpatient (3 services per day) for CMHCs                          | \$136.36                                      |
| 5852        | Intensive Outpatient (4 or more services per day) for CMHCs                  | \$169.84                                      |
| 5853        | Partial Hospitalization (3 services per day) for CMHCs                       | \$136.36                                      |
| 5854        | Partial Hospitalization (4 or more services per day) for CMHCs               | \$169.84                                      |
| 5861        | Intensive Outpatient (3 services per day) for hospital-based IOPs            | \$340.90                                      |
| 5862        | Intensive Outpatient (4 or more services per day) for hospital-based IOPs    | \$424.60                                      |
| 5863        | Partial Hospitalization (3 services per day) for hospital-based PHPs         | \$340.90                                      |
| 5864        | Partial Hospitalization (4 or more services per day) for hospital-based PHPs | \$424.60                                      |

**IX. SERVICES THAT WILL BE PAID ONLY AS INPATIENT SERVICES (Page 449)**

CMS proposes to eliminate the IPO list over the course of the next 3 years, starting with the removal of 285 mostly musculoskeletal-related services, as provided in Table 69, in CY 2026.

**X. NONRECURRING POLICY CHANGES (Page 478)**

CMS addresses the following non-recurring policy changes.

**Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)**

For CY 2026, CMS is proposing to address drug administration services provided at excepted PBDs. CMS proposes to address payment for these services across the APC family.

CMS has concluded that a 70 percent increase in excepted hospital outpatient department volume over a 10-year period was at least partially driven by the payment differential between the physician office and OPD setting.

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 PBD

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excepted from section 603 of the **Bipartisan Budget Act** of 2015. CMS is also including a comment solicitation on expanding the agency's method to control unnecessary increases in the volume of the clinic visit service provided in on-campus hospital outpatient departments.

For CY 2026, CMS estimates this provision reduces OPSS 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. (Page 496)

CMS is proposing to exempt rural SCHs from payment of the site-specific PFS-equivalent payment for drug administration services, when furnished at an off-campus PBD exempted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines). Under this proposed policy, a rural SCH would continue to bill services in APC family 569X with the "PO" modifier for CY 2026 and the payment rate for such services would continue be the full OPSS payment without the PFS relativity adjustment. (Page 503)

**Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients** (Page 507)

In the CY 2026 Physician Fee Schedule (PFS) proposed rule, CMS proposed to revise the definition of direct supervision at § 410.26(a)(2) and § 410.32(b)(3)(ii) to make permanent the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS, except for services that have a global surgery indicator of 010 or 090. This information can be found in the PFS PRRVU public use file at: <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files>.

**Medical Review of Certain Inpatient Hospital Admissions Under Medicare Part A for CY 2026 and Subsequent Years** (Page 510)

Services on the IPO list are not subject to the 2-midnight rule for purposes of determining whether payment is appropriate under Medicare Part A. However, the 2-midnight rule is applicable once services have been removed from the IPO list. (Page 516)

**XI. PROPOSED CY 2026 OPSS PAYMENT STATUS AND COMMENT INDICATORS** (Page 520)

For CY 2026 and subsequent years, CMS proposes to create a new status indicator "S1". CMS proposes this new status indicator to indicate that the skin substitute product is paid separately from other procedure codes under the OPSS. CMS proposes to assign all existing HCPCS codes describing skin substitute products to status indicator "S1" for CY 2026.

The complete list of proposed CY 2026 payment status indicators and their definitions is displayed in Addendum D1 and available for download under related links "2026 NPRM OPSS Addenda" at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-p>

The proposed CY 2026 payment status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B and available for download under related links "2026 NPRM OPSS Addenda" at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-p>

CMS solicits public comments on the proposed definitions of the OPSS payment status indicators for CY 2026. (Page 522)

**XII MEDPAC RECOMMENDATIONS** (Page 522)

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### **XIII. PROPOSED UPDATES TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM** (Page 524)

#### ***Proposed ASC Treatment of New and Revised Codes*** (Page 524)

##### *1. April 2025 HCPCS Codes*

For the April 2025 update, there were no new CPT codes; however, there were several new Level II HCPCS codes.

The rule's table 73 lists the new Level II HCPCS codes that were implemented April 1, 2025.  
(Page 528)

##### *2. July 2025 HCPCS Codes Rule Comment Solicitation* (Page 963)

Table 74 lists the new HCPCS codes that were effective July 1, 2025.

##### *3. October 2025 HCPCS Codes Final Rule Comment Solicitation* (Page 531)

For CY 2026, CMS' proposes that the Level II HCPCS codes that will be effective October 1, 2025, would be "NI" in Addendum BB to the CY 2026

##### *4. January 2026 HCPCS Codes* (Page 532)

Level II HCPCS codes will be released to the public through the CY 2026 OPPS/ASC final rule with comment period, January 2026 ASC Update CR, and the CMS HCPCS website. In summary, CMS solicits public comments on the proposed CY 2026 payment indicators for the new Category I and III CPT codes that will be effective January 1, 2026. Because these codes are listed in Addendum AA and Addendum BB with short descriptors only, CMS is listing them again in Addendum O with the long descriptors. CMS also proposes to finalize the payment indicator for these codes (with their final CPT code numbers) in the CY 2026 OPPS/ASC final rule with comment period.

#### ***Proposed OPPS C-APC Complexity Adjustment Policy*** (Page 541)

CMS applies a complexity adjustment by promoting qualifying paired "J1" service code combinations or paired code combinations of "J1" services and add-on codes from the originating Comprehensive APC (C-APC) (the C-APC to which the designated primary service is first assigned) to the next higher paying C-APC in the same clinical family of C-APCs.

For CY 2026, CMS proposes to continue the special payment policy and methodology for OPPS complexity-adjusted C-APCs that was finalized in the CY 2023 OPPS/ASC final rule with comment period.  
(Page 542)

#### ***Proposed Low Volume APCs and Limit on ASC Payment Rates for Procedures Assigned to Low Volume APCs*** (Page 543)

Table 76 includes the CY 2024 claims available for rate-setting for each of the APCs CMS is proposing to designate as a low volume APC for CY 2026.

#### ***Proposed Payment for Covered Ancillary Services for CY 2026*** (Page 545)

Covered ancillary services and their final payment indicators for CY 2025 are listed in Addendum BB.  
(Page 985)

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**CY 2026 Proposed Office-Based Procedures (Page 548)**

CMS says CPT code 21930 (Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm) meets the criteria for designation as permanently office-based. The data indicated that this procedure is performed more than 50 percent of the time in physicians' offices, and the services are of a level of complexity consistent with other procedures performed routinely in physicians' offices. CMS has included CPT code 21930 in its list of surgical procedures to permanently designate as office-based for CY 2026 in Table 77. (Page 552)

CMS proposes to permanently remove the temporarily office-based designation for CPT code 15013 and HCPCS code C8002.

**CY 2026 Proposed Device Intensive Procedures (Page 554)**

CMS is proposing that the OPSS payment rates used for rate-setting under the ASC payment system for CY 2026 and subsequent years would not incorporate the two percent prospective offset to the OPSS conversion factor as a result of the 340B remedy offset that CMS proposes to implement in this proposed rule.

For final CY 2026 device offset percentages based on claims data for this final rule, CMS refers readers to Addendum FF. (Page 558)

**Proposed Additions to ASC Covered Surgical Procedures and Covered Ancillary Services Lists (Page 562)**

For CY 2026, CMS proposes to revise the ASC CPL criteria under 42 CFR 416.166, modifying the general standard criteria and eliminating five of the general exclusion criteria.

Using these revised criteria, CMS proposes to add approximately 276 potential surgery or surgery like codes to the CPL that are not on the CY 2025 IPO list. Additionally, CMS proposes to add 271 surgery or surgery-like codes to the CPL that are currently on the IPO list for CY 2026. These codes, along with their long descriptors and proposed payment indicator assignments, are listed in Tables 80 and 81. (Pages 569-590)

**Proposed CY 2026 Non-Opioid Policy for Pain Relief Under the OPSS and ASC Payment System (Page 593)**

For CY 2026, CMS proposes to continue the policies finalized in the CY 2025 OPSS ASC final rule without modification. (Page 601)

CMS is proposing five drugs and six devices to qualify as non-opioid treatments for pain relief, and CMS proposes these products be paid separately in both the HOPD and ASC settings, starting in CY 2026 as identified in Table 82. (Page 604)

**Proposed New Technology Intraocular Lenses (NTIOLs) (Page 608)**

CMS did not receive any requests for review to establish a new NTIOL class for CY 2024.

The current payment adjustment for a five-year period from the implementation date of a new NTIOL class is \$50 per lens. This amount has not changed since 1999.

**XIV. CROSS-PROGRAM PROPOSALS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING (OQR), RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR), AND AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAMS (Page 623)**

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***Proposed Changes to the Hospital OQR, REHQR, and ASCQR Program Measure Sets***  
(Page 624)

1. Proposed Removal of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the Hospital OQR and ASCQR Programs Beginning with the CY 2024 Reporting Period/CY 2026 Payment Determination.
  2. Proposed Removal of the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program Beginning with the CY 2025 Reporting Period/CY 2027 Payment or Program Determination
  3. Proposed Removal of Two Social Drivers (Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health) of Health Measures from the Hospital OQR, REHQR, and ASCQR Programs Beginning with the CY 2025 Reporting Period. (Page 628)
- XV. HOSPITAL OUTPATIENT QUALITY REPORTING (OQR) PROGRAM** (Page 633)

***Proposed Changes to the Hospital OQR Program Measure Set*** (Page 634)

CMS is proposing to adopt the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) beginning with voluntary reporting for the CY 2027 reporting period followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination.

In addition, CMS proposes to remove the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure and the Left Without Being Seen measure, beginning with the CY 2028 reporting period/CY 2030 payment determination.

CMS proposes to modify the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Outpatient) measure (Excessive Radiation eCQM) from mandatory reporting to voluntary reporting beginning with the CY 2027 reporting period.

***Summary of Previously Finalized and Newly Proposed Hospital OQR Program Measure Set for CY 2026 to CY 2031 Payment Determinations*** (Page 649)

The rule's Table 84 summarizes the previously finalized and newly proposed Hospital OQR Program measure set for the CY 2026 to CY 2031 payment determinations, which would remove the HCHE, Screening for SDOH, Screen Positive Rate for SDOH, and COVID-19 Vaccination Coverage Among HCP measures; modify reporting requirements for the Excessive Radiation eCQM from mandatory to voluntary reporting beginning with the CY 2027 reporting period; remove the Left Without Being Seen and the Median Time for Discharged ED Patients measures; and add the Emergency Care Access & Timeliness eCQM.

***Payment Reduction for Hospitals That Fail to Meet the Hospital OQR Program Requirements for the CY 2026 Payment Determination*** (Page 654)

Hospitals that fail to report data required to be submitted on measures selected by the Secretary, in the form and manner, and at a time, specified by the Secretary will incur a 2.0-percentage point reduction to their Outpatient Department (OPD) fee schedule increase factor; that is, the annual payment update factor.

**XVI. RURAL EMERGENCY HOSPITAL QUALITY REPORTING (REHQR) PROGRAM** (Page 659)

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CMS proposes to adopt the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) beginning with the CY 2027 reporting period/CY 2029 program determination as an alternative to reporting the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure.

Table 85 summarizes the previously finalized and newly proposed REHQR Program measure set for the CY 2026 to CY 2031 program determinations, which would remove the Hospital Commitment to Health Equity (HCHE), Screening for SDOH, and Screen Positive Rate for SDOH measures and add the Emergency Care Access & Timeliness eCQM. (Page 673)

## **XVII. AMBULATORY SURGICAL CENTER QUALITY REPORTING (ASCQR) PROGRAM**

(Page 682)

### ***Proposed Changes to the ASCQR Program Measure Set*** (Page 683)

CMS proposes to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination.

Table 86 summarizes the previously finalized and newly proposed ASCQR Program measure set for the CY 2026 to CY 2031 payment determinations. Table 86 reflects CMS' proposals to remove the FCHE, Screening for SDOH, Screen Positive Rate for SDOH, and the COVID-19 Vaccination Coverage Among HCP measures and add the Information Transfer PRO-PM as discussed in section XVII.B.1. of this proposed rule. (Page 692)

### ***Payment Reduction for ASCs That Fail to Meet the ASCQR Program Requirements*** (Page 698)

Any annual increase in certain payment rates under the ASC payment system shall be reduced by 2.0-percentage points for ASCs that fail to meet the reporting requirements of the ASCQR Program.

## **XVIII. OVERALL HOSPITAL QUALITY STAR RATING MODIFICATION TO EMPHASIZE THE SAFETY of CARE MEASURE GROUP** (Page 701)

*Note: The following material is from CMS' fact sheet accompanying this rule.*

Patient safety constitutes a fundamental component of the CMS National Quality Strategy, representing a sustained commitment to fostering optimal health outcomes and ensuring the safest possible care for all patients. CMS is proposing to update the methodology used to calculate the Overall Hospital Quality Star Rating to emphasize the contribution of the Safety of Care measure group in hospitals' ratings.

Measures that are publicly reported on the provider comparison tool on Medicare.gov (<https://www.medicare.gov/care-compare>) are organized into five conceptually coherent measure groups under the Overall Star Rating: Safety of Care, Mortality, Readmission, Patient Experience, and Timely and Effective Care.

CMS is proposing to make a 2-stage methodologic update. This methodology update will retain all aspects of the current methodology (e.g., annual refresh, inclusion and exclusion criteria for measures, standardization of measure scores, calculation of measure group & summary scores, use of K-means clustering to assign a rating) and proposes adding a new methodology step (which will become the final step of the methodology):

- **Stage 1: Implement a 4-star cap for hospitals in the lowest quartile of the Safety of Care measure group performance in Calendar Year 2026.**

CMS proposes limiting hospitals in the lowest quartile (lowest-performing 25 percent, indicating poor performance relative to other hospitals) of the Safety of Care measure group (based on at least three measure scores) to a maximum of 4 stars out of 5. This methodology update will apply a cap to any hospital that is initially assigned 5 stars in step 8 of the methodology (K-means clustering) but has a Safety of Care score in the lowest-performing quartile (based on at least three Safety of Care measures) to 4 stars.

- **Stage 2: Implement a blanket 1-Star reduction for hospitals in the lowest quartile of Safety of Care measure group performance beginning in Calendar Year 2027.**

CMS proposes reducing the Overall Hospital Quality Star Rating of any hospital in the lowest quartile of the Safety of Care measure group (based on at least three measure scores) by 1 star, to a minimum 1-star rating. This methodology update will apply a blanket reduction of stars to any hospital initially assigned a 2-, 3-, 4- or 5-star rating in step 8 of the methodology (K-means clustering), but that has a Safety of Care score in the lowest-performing quartile (based on at least three Safety of Care measures). These hospitals would have their star ratings reduced to 1, 2, 3, or 4 stars, respectively. Since the minimum possible Overall Hospital Star Rating will remain 1 star, hospitals already receiving one star would not face further star reduction and, therefore, would effectively be exempt from this methodology update consistent with the established assignment of ratings between 1-5 whole stars.

Stage 1 methodology update will be used to calculate the Overall Hospital Star Rating in 2026, while the Stage 2 methodology update will be used to permanently calculate the Overall Hospital Star Rating beginning in 2027 and later years. The Stage 2 methodology update is intended to replace the Stage 1 methodology update, not to supplement it. That is, no 5-star hospital will be capped to 4 stars and then further reduced to 3 stars; in both stages, 5-star hospitals could only be reduced to 4 stars.

Only rated hospitals with at least 3 Safety of Care measures would be subject to either the 4-star cap or the 1-star reduction. This is to ensure that any reduction is based on reliable measurement across multiple elements of patient safety. Hospitals with 1 or 2 Safety of Care measures will still receive a Safety of Care group score and their star rating will reflect their performance on these measures, but they would not be subject to additional reduction based on limited information. Hospitals with 0 Safety of Care measures do not receive a Safety of Care group score, and their patient safety performance is not reflected positively or negatively in their Overall Star Rating due to insufficient data for reliable measurement of patient safety outcomes.

Proposed changes reflect CMS' commitment to improving healthcare outcomes and advancing patient safety and aims to:

- Address the acute concern of hospitals receiving the highest possible 5-star rating despite performing in the lowest quartile of the Safety of Care measure group.
- Emphasize the contributions of safety more broadly by applying a higher standard for patient safety to hospitals across a broad range of overall performance, rather than limiting it to the few 5-star hospitals in the lowest quartile of Safety of Care (with at least three Safety of Care measures).

Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare

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Additionally, CMS is seeking public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program through a standalone RFI available at <https://www.cms.gov/medicare-regulatory-relief-rfi>. The public should submit all comments in response to this RFI through the provided weblink.

## **XIX. UPDATES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES** (Page 712)

CMS proposes amendments to the hospital price transparency (HPT) regulations to enhance clarity and standardization in hospital disclosure of standard charges.

Specifically, CMS proposes revisions to § 180.20 to add definitions for “tenth (10<sup>th</sup>) percentile allowed amount,” “median allowed amount,” and “ninetieth (90<sup>th</sup>) percentile allowed,” which are values a hospital would encode when a payer-specific negotiated charge is based on a percentage or algorithm, to more accurately reflect the distribution of actual amounts that a hospital has received for an item or service.

CMS proposes revisions to § 180.50 to remove the requirement for hospitals to disclose the estimated allowed amount, and, instead, require hospitals, beginning January 1, 2026, to disclose the 10<sup>th</sup> percentile, median, and 90<sup>th</sup> percentile allowed amounts, as well as the count of allowed amounts, in machine-readable files (MRFs) when payer-specific negotiated charges are based on percentages or algorithms.

CMS also proposes to require that hospitals use electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data to calculate and encode these values, and CMS proposes to require that hospitals comply with specific instructions regarding the methodology, including the lookback period, that must be used to calculate those amounts.

CMS proposes revisions to § 180.50 to require hospitals, beginning January 1, 2026, to attest that in the MRF, the hospital has included all applicable standard charge information in accordance with the requirements of this section and the information encoded is true, accurate, and complete as of the date in the file.

CMS proposes that hospitals attest in the MRF that the hospital has included all applicable payer-specific negotiated charges as dollars that can be expressed as a dollar amount, and for payer-specific negotiated charges that are not knowable in advance or cannot be expressed as a dollar amount, the hospital has provided in the MRF all necessary information available to the hospital for the public to be able to derive a dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm, or formula.

CMS also proposes that hospitals encode in the MRF the name of the hospital chief executive officer, president, or senior official designated to oversee the encoding of true, accurate, and complete data. In addition, to advance the comparability of HPT data with other healthcare data, CMS proposes to require that hospitals encode their National Provider Identifier(s) (NPIs) in the MRFs.

Finally, to encourage faster resolution and payment of CMPs, and in exchange for a hospital’s admission of having violated HPT requirements, CMS proposes to update § 180.90 to reduce the amount of a civil monetary penalties (CMPs) by 35 percent, under certain conditions, when a hospital waives its right to an ALJ hearing. These proposed changes aim to improve transparency in hospital pricing, facilitate efficient enforcement of the HPT requirements, and empower consumers with actionable pricing information. (Page 717)

### **Comment**

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This section extends nearly 50 pages. It contains numerous definitions and changes, including an emphasis on hospital compliance with reporting such information.

**XX. PROPOSED MARKET-BASED MEDICARE SEVERITY-DIAGNOSIS RELATED GROUPS (MS-DRG) RELATIVE WEIGHT DATA COLLECTION AND CHANGE IN METHODOLOGY FOR CALCULATING MS-DRG RELATIVE WEIGHTS UNDER THE INPATIENT PROSPECTIVE PAYMENT SYSTEM (Page 758)**

CMS proposes for cost reporting periods ending on or after January 1, 2026, to collect on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its MAOs, by MS-DRG. CMS proposes to utilize this data within a proposed methodology for calculating the IPPS MS-DRG relative weights to reflect relative market-based pricing effective in FY 2029.

**XXI. GRADUATE MEDICAL EDUCATION ACCREDITATION (Page 780)**

In order to ensure that GME accreditation for approved medical residency programs complies with applicable laws related to race-based admission policies and to improve the accreditation process, CMS is proposing that accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place, diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of Federal law. CMS also notes that the Secretary may certify other organizations as accreditors to increase the potential for competition in the accreditation space and improve the quality of the accreditation process.

**FINAL THOUGHTS**

The length of these rules continue to grow every year. Much is do to the inclusion of prior history. It is obvious that CMS begins most sections with prior rule-making history that builds to the proposed changes being addressed. It would be most helpful to reverse this process. That is, start the discussion with the proposed changes, and if necessary add prior rulemaking that would help the reader understand the changes.

Once again, with respect to outliers, CMS says for CY 2024, it did not meet the outlier target by 0.08 percent of total aggregated OPPS payments. The result is no adjustment for underpaying hospitals.

The reader should not overlook CMS' Economic Analyses starting on Page 836. CMS devotes much attention to the costs of the changes being made.

Several apparent errors are highlighted in this analysis of the rule. Most involved typographical mistakes. It is difficult to follow CMS' Table of Contents, especially when the material is extensive. Its difficult to follow the logic of the numbering when only a number or letter appears. This makes the reader keep refreshing the data to understand section details.

It is unusual for a rule of this size to be published in only 2 days after appearing on the **Federal Register**.

Providers need to pay extra attention on the requirements to provide the public a list of their charges. CMS is fully cognizant at the number of facilities failing to comply with this item.

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