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Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots

December 5, 2025

Background & Key Takeaways

On November 21, 2025 the Centers for Medicare & Medicaid Services (CMS) issued the annual Final Rule to update the Calendar Year (CY) 2026 Medicare payment rates for services payable under the Hospital Outpatient Prospective Payment System (OPPS) (hereinafter, "Final Rule"). The Final Rule includes changes to payment policies, payment rates and quality provisions for Medicare patients who receive care at hospital outpatient departments (OPDs) or receive care at ambulatory surgical centers (ASCs). The Final Rule expands existing site neutral payment policy to include drug administration services, maintains the previously finalized 340B remedy offset, modifies the Overall Hospital Quality Star Ratings methodology, provides updates to hospital price transparency (HPT) regulations, and updates the Hospital Outpatient Quality Reporting (OQR) Program, including the removal of two chart-abstracted measures.

A CMS fact sheet on the Final Rule is available here with additional information on the final updates HPT regulations available here.

Most policies provided in the Final Rule go into effect on January 1, 2026. However, CMS is delaying enforcement of finalized hospital price transparency requirements until April 1, 2026, to give hospitals additional time to comply.

OPPS Payment Update

For CY 2026, CMS finalized policy to apply an OPD fee schedule increase factor of 2.6 percent, except for those hospitals not meeting certain quality reporting requirements, which would be subject to a 2-percentage point reduction in payments.[1] The fee schedule increase factor was driven by the final inpatient hospital market basket percentage increase of 3.3 percent for services paid under the Hospital Inpatient Prospective Payment System (IPPS) reduced by a final productivity adjustment of 0.7 percentage points.[2] Based on this update, CMS estimates that total CY 2026 payments to OPPS providers will be approximately $101 billion, an increase of approximately $8 billion compared to estimated CY 2025 OPPS payments. CMS also finalized a CY 2026 conversion factor (CF) of $91.415 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) Program requirements.

In the Final Rule, CMS delayed the proposed 340B remedy offset for one year, which would have reduced payments by 2 percentage points (rather than 0.5) for hospitals subject to this offset, as further detailed below. The CF for these hospitals is $90.967.

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[1] The Proposed Rule had a fee schedule increase of 2.4 percent, so the Final Rule's OPD fee schedule increase factor is 0.2 percentage points higher than the Proposed Rule.
[2] This finalized figure is a change from the Proposed Rule's (3.2 percent market based adjustment minus 0.8 for productivity adjustment)

As highlighted in Table 1, CMS estimates that, for CY 2026, the cumulative effect of all proposed changes will increase Medicare OPPS payments by 2.4 percent for all providers and 2.5 percent for all hospitals.

Table 1. Estimated Impact of the Certain Final CY 2026 Changes for the Hospital OPPS

	# of Hospitals (1)	All budget neutral changes with Market Basket Update (2)***	Payment Adjustment for Drug Admin. At Off Campus PBDs (3)****	Final CY 2026 Update of All Changes with Outlier (4)^
All providers	3,543	2.7	-0.3	**2.4**
All hospitals*	3,439	2.8	-0.3	**2.5**
Urban hospitals	2755	2.8	-0.3	**2.6**
Rural hospitals	684	2.4	-0.1	**2.3**
Non-teaching status hospitals	2058	2.7	-0.1	**2.6**
Minor teaching status hospitals	920	2.9	-0.2	**2.7**
Major teaching status hospitals	461	2.6	-0.4	**2.4**

*Excludes hospitals held harmless and Community Mental Health Centers (CMHCs).
***Column (2) shows the impact of all budget neutrality adjustments and the addition of the final 2.6 percent OPD fee schedule update factor (3.3 percent reduced by 0.7 percentage points for the productivity adjustment). Overall, these changes would increase payments to urban hospitals by 2.8 percent and to rural hospitals by 2.4 percent in CY 2026.
****Column (3) shows the separate impact of the final payment adjustment for drug administration services furnished at excepted off campus providers.
^Column (4) shows the overall impact of the final CY 2026 policies on each hospital group by comparing all CY 2026 changes to estimated CY 2025 payments. It reflects the combined budget-neutral effects from Columns 2 and 3, the off-campus drug administration policy, the OPD fee schedule increase, estimated OPPS outlier payments, the Hospital OQR Program payment reductions for hospitals that did not meet reporting requirements, and other adjustments to CY 2026 OPPS payments.

CY 2026 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 (340B Remedy Offset)

From 2018 through September 2022, CMS reimbursed for certain 340B drugs under the OPPS at ASP minus 22.5 percent, while increasing payments for non-drug items and services to keep the policy budget neutral.[3] In June 2022, the Supreme Court ruled that CMS could not set different payment rates for 340B drugs without first surveying hospitals' acquisition costs.[4] In CY 2023 rulemaking, CMS restored equal payment for 340B and non-340B drugs and provided policy for a one-time lump sum payment to affected 340B covered entity hospitals for the prior shortfalls.[5,6] In the CY 2024 OPPS Final Rule, CMS finalized a 340B remedy offset policy to reduce the conversion factor for non-drug services by 0.5 percent per year, except for hospitals that joined Medicare after 2018. The 0.5 percent reduction to the conversion factor would continue until the estimated $7.8 billion in increased payments for non-drug items and services made from CY 2018–2022 was recouped.[7]

[3] https://www.govinfo.gov/content/pkg/FR-2017-11-13/pdf/2017-23932.pdf
[4] Am. Hosp. Ass'n v. Becerra, 142 S. Ct. 1896, 1906, https://supreme.justia.com/cases/federal/us/596/20-1114/
[5] https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf
[6] https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug
[7] https://www.govinfo.gov/content/pkg/FR-2023-11-08/pdf/2023-24407.pdf. CMS estimated the offset would be reached in about 16 years.

In the Final Rule, CMS declined to adopt the proposal to modify the -0.5 percent reduction to the OPPS conversion factor to -2 percent. Instead, CMS will maintain the -0.5 percent reduction for CY 2026 and indicates hospitals should anticipate a larger negative adjustment will be proposed for CY 2027. CMS stated that comments from hospitals convinced the agency that an additional year is needed for time for providers to adequately prepare for the change in policy. For providers affected by the 340B remedy offset, payments are expected to be reduced by about $275 million in CY 2026.

Additionally, related to 340B, CMS elaborated on the agency's upcoming drug acquisition cost survey, as noted below.

Site Neutral Payment Policies

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

Starting in CY 2026, CMS finalized the proposal to apply a Physician Fee Schedule (PFS) relativity adjuster of 40 percent for HCPCS codes assigned to the drug administration services Ambulatory Payment Classifications (APCs) 5691-5694 (Levels 1-4 Drug Administration), when provided at an excepted off-campus PBD in a non-budget neutral manner.[8,9,10] CMS finalized this policy despite significant opposition from hospitals that highlighted legal concerns and key differences between sites of care. For CY 2026, CMS estimates this policy will reduce OPPS spending by $290 million, with $220 million of the savings accruing to Medicare, and $70 million saved by Medicare beneficiaries in the form of reduced beneficiary coinsurance.[11] The estimated payment impact of this policy is -0.3 percent for hospitals, as displayed in Column 5 in Table 1 posted above. CMS plans to monitor the effects of this policy to ensure that beneficiaries continue to have access to quality care.

CMS also finalized an exemption for rural Sole Community Hospitals (SCHs) because CMS reviewed utilization data for drug administration services at rural SCHs and did not find strong evidence that drug administration services are being utilized at an unnecessary volume at excepted off-campus PBDs of rural SCHs.[12] CMS also indicates this exemption aligns with the special payment treatment rural SCHs currently receive under the OPPS.

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[8]Section 1833(t)(2)(F) of the Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1833.htm. In the Final Rule, CMS affirms this authority is upheld in the D.C. Circuit Court opinion in *American Hospital Association v. Azar* (2020). This ruling said reducing reimbursement rates for specific outpatient services qualifies as a valid method to control unnecessary increases in service volume.
[9] In the Final Rule, CMS says this proposal aligns with President Trump's Executive Order (E.O.) 14273, "Lowering Drug Prices by Once Again Putting Americans First." Section 11 of the E.O., "Reducing Costly Care for Seniors," directs the Secretary to "evaluate and, if appropriate and consistent with applicable law, propose regulations to ensure that payment within the Medicare program is not encouraging a shift in drug administration volume away from less costly physician office settings to more expensive hospital outpatient departments."
[10] In the Final Rule, CMS interprets budget neutrality rules as not applying to volume control methods under section 1833(t)(2)(F) of the Social Security Act. CMS states that volume control methods are distinct from "adjustments" (like wage or outlier adjustments), which explicitly require budget neutrality and the agency has the authority to later adjust the conversion factor if service volume exceeds expectations.
[11] Table 166 (pg. 1579) of the Final Rule gives the 10-year estimated impact of this policy of changes to drug administration services when furnished at excepted off-campus providers. Table 170 (pg. 1600) of the Final Rule illustrates the classification of expenditures for the CY 2026 estimated hospital OPPS incurred benefit impacts associated with the final CY 2026 OPD fee schedule increase and the final policy for drug administration services furnished at excepted off-campus PBDs.
[12] CMS notes that rural areas often experience lower availability of health care professionals and hospitals than urban areas and hospital closures in rural communities are associated with lower access to health care and worse health outcomes.

Continuation of Payment Policy for Radiation Therapy Services Furnished at Non-Excepted Off-Campus Provider Based Departments (PBDs)

CMS previously required non-excepted off-campus PBDs to bill radiation therapy services using HCPCS G-codes (G6001–G6017), which were recognized under the PFS but not under OPPS. In the CY 2026 PFS Final Rule, CMS finalized deletion of these G-codes effective January 1, 2026, because revised CPT codes (77402, 77407, 77412) will be used to report these services. In the Final Rule, CMS finalized that effective January 1, 2026, non-excepted off-campus PBDs must use the revised radiation treatment CPT codes from the CY 2026 PFS Final Rule. In contrast to the Proposed Rule, CMS finalized different payment values for the revised radiation treatment CPT codes. Table 98 (pg. 436) in the Final Rule displays the current and revised descriptors for the CPT codes replacing the deleted G-codes, while Addenda B on the CMS website provides the finalized payment rates for these new CPT codes.

Wage Index Changes

In the Final Rule, CMS estimates that the update of the wage index, based on the fiscal year (FY) 2026 IPPS proposed rule wage index, will result in a 0.1 percent increase for urban hospitals under the OPPS and a 0.2 percent increase for rural hospitals. Additionally, for CY 2026, CMS finalized policy to continue implementing various provisions affecting the wage index, such as reclassification of hospitals to different geographic areas, the rural floor provisions, the imputed floor wage index adjustment in all-urban states, an adjustment for occupational mix, an adjustment to the wage index based on commuting patterns of employees (the out-migration adjustment) and the permanent 5 percent cap on any decrease to a hospital's wage index from its wage index in a prior FY.

Further, for CY 2026 and subsequent years, CMS finalized policy to discontinue the low wage index hospital policy under OPPS, aligning it with the FY 2026 IPPS Final Rule decision to remove the policy after the D.C. Circuit's *Bridgeport Hospital v. Becerra* 2024 ruling.[13] The policy, in place from CY 2020–2024, boosted wage indexes for hospitals below the 25th percentile. With this final policy, CMS is now returning to its longstanding practice of using the IPPS wage index as the adjustment factor for OPPS starting in CY 2026.

To align OPPS and IPPS wage index values in CY 2026, CMS finalized basing the 5 percent cap on wage index decreases on the FY 2025 IPPS wage index, rather than the CY 2025 OPPS wage index. Because this shift could otherwise result in wage index reductions greater than 5 percent for some hospitals, CMS also finalized a transitional payment exception under the OPPS for CY 2026 to mitigate the impact on low wage index hospitals significantly affected by the discontinuation of the low wage index hospital policy. Under this finalized exception, hospitals whose CY 2026 wage index decreases by more than 9.75 percent compared to CY 2024 will receive additional payment, effectively setting their CY 2026 wage index at 90.25 percent of the CY 2024 value. This adjustment will be applied after the standard 5 percent cap and implemented in a budget-neutral manner.

Hospital Outpatient Outlier Payments

OPPS provides outlier payments (added to the APC amount) to help mitigate financial risks associated with high-cost and complex procedures that could present a hospital with significant

[13] In *Bridgeport* the court ruled that the Department of Health and Human Services (HHS) lacked authority to implement the low wage index hospital policy and vacated both the policy and the related budget neutrality adjustment. https://cases.justia.com/federal/appellate-courts/cadc/22-5249/22-5249-2024-07-23.pdf?ts=1721746878

financial loss. For CY 2026, hospital outlier payments will continue to equal 1.0 percent of total OPPS payments, triggered when costs exceed 1.75 times the APC rate plus a fixed-dollar threshold of $6,225.

Updates Affecting OPPS Payments

Comprehensive APCs (C-APCs) Complexity Adjustments

CMS applies complexity adjustments to increase payment when a claim includes paired "J1" services or add-on codes that reflect a more complex or more costly form or version of the primary service. For CY 2026, CMS did not propose any changes to the existing policy related to complexity adjustments, but in the Final Rule it expanded the list of services eligible for C-APC complexity adjustments. Specifically, CMS added nine new code combinations that were suggested by public commenters and met the agency's criteria for frequency and cost.[14,15]

Payment for Non-Opioid Treatments for Pain Relief

The Consolidated Appropriations Act (CAA), 2023 provides temporary additional payments for non-opioid treatments for pain relief furnished between January 1, 2025 and January 1, 2028. For CY 2026, CMS finalized continuation of the CY 2025 policy of providing temporary separate payment for qualifying non-opioid treatments for pain relief under OPPS. In the Final Rule, Table 136 (pgs. 1138-1140), lists the qualifying Medicare non-opioid medical devices for post-surgical pain relief that will receive separate payment beginning or continuing January 1, 2026 while Table 137 (pgs. 1140-1142) provides the final payment limitations for these products for CY 2026. To support access to new non-opioid products, CMS established a quarterly process to review and approve new products during a CY, as outlined in the Final Rule (pgs. 1105-1106).

OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals

Notice of Intent to Conduct Medicare OPPS Drugs Acquisition Cost Survey

In the Final Rule, CMS finalized the agency's intent to conduct a survey of the acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS, subject to clarifications and modifications discussed in the Final Rule.[16] As noted in the Final Rule, CMS will conduct this survey from January 1, 2026 through March 31, 2026.[17] CMS explained that the survey is intended to be as low-burden as possible for hospitals, as both the survey instrument and the reporting process were designed to reduce staffing and financial demands. Additionally, the survey instrument will consist of a streamlined online portal, where hospitals can either directly enter acquisition costs or download and reupload an excel template of acquisition costs. CMS plans to support hospitals during the drug acquisition cost survey by offering technical assistance and

[14] See pg. 53 of the Final Rule for the nine added code combinations.
[15] The final complexity adjustments for "J1" and add-on code combinations for CY 2026, are located in Addendum J of the Final Rule available on the CMS website.
[16] This survey will apply to all hospitals paid under the OPPS, which for purposes of our burden calculations we estimated to be 3,500 hospitals in the CY 2026 OPPS/ASC proposed rule. Based on our understanding of hospital practices, in the CY 2026 OPPS/ASC proposed rule we estimated the total time for each hospital to respond to the survey to be 73.5 hours, which includes time required to review instructions, gather data (including potentially from hospital wholesalers), perform basic addition calculations, and enter data.
[17] The survey instrument consists of a streamlined online portal, where hospitals can either directly enter acquisition costs or download and reupload an excel template of acquisition costs. CMS will provide technical assistance for any issues that arise during the submission process.

engaging in education and outreach efforts.[18] Also, CMS indicates that a new information collection request will be submitted to the Office of Management and Budget for review under control number 0938-1487 (CMS-10931), signaling CMS may be making modifications to the survey in response to public comment.[19]

The CMS survey will ask hospitals to report the total acquisition cost, net of all rebates and discounts, of each drug by National Drug Code (NDC) purchased during the 1-year timeframe of July 1, 2024, to June 30, 2025. CMS will publish a draft list of the NDCs included in the survey and plans to ask hospitals to separately list their acquisition costs for NDCs acquired through the 340B program and outside of the 340B program. CMS intends to use the survey to inform CY 2027 payment policy.

In the Final Rule, CMS explained that it has not yet decided how, if at all, the agency will consider non-responses to the survey. CMS indicates that policies related to non-response will be included in future rulemaking, as soon as CY 2027, if CMS adopts payment rates based on the results of the survey. Also, CMS noted that many commenters claimed CMS lacks statutory authority to mandate hospital participation in the drug acquisition cost survey while others supported making the survey mandatory to ensure complete and accurate data for setting CY 2027 OPPS rates. CMS responded that the agency interprets the section of the Social Security Act that outlines a drug acquisition cost survey for hospital outpatient drugs as requiring both the agency to design drug acquisition cost surveys and hospitals to respond, even though the statute does not specify penalties for non-response.[20] CMS emphasized that hospital non-responses to the required survey are still meaningful data that may inform future payment rates. More information about the survey is available on a newly launched CMS website.

OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Payment Status: Finalized Packaging Threshold

For CY 2026, CMS finalized a packaging threshold of $140 for drugs, biologicals and therapeutic radiopharmaceuticals. For diagnostic radiopharmaceuticals, CMS finalized packaging items with a per day cost less than or equal to $655, while items with a per day cost greater than $655 are separately payable.

Payment for Diagnostic Radiopharmaceuticals

For CY 2026, CMS finalized assigning HCPCS codes for diagnostic radiopharmaceuticals with per-day costs above the $655 packaging threshold to status indicator “K”, signifying separate payment based on the code’s arithmetic Mean Unit Cost (MUC).[21,22] HCPCS codes for radiopharmaceuticals at or below the threshold would retain status indicator “N”, meaning their payment remains packaged with the associated service.

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[18] A full list of these efforts can be found on pgs. 779-780 in the Final Rule.
[19] The OMB control number will not be valid until formally approved by OMB.
[20] https://www.ssa.gov/OP_Home/ssact/title18/1833.htm
[21] The finalized list of diagnostic radiopharmaceuticals that CMS calculated as having per day costs that exceed $655 can be found on pg. 102 of the Final Rule.
[22] For CY 2026, CMS plans to continue to use paying for diagnostic radiopharmaceuticals using mean unit cost would appropriately pay for the average price of non pass-through separately payable diagnostic radiopharmaceuticals for the applicable year.

Medicare Part B Drugs without a Medicaid National Drug Rebate Agreement (NDRA)

In the Final Rule, CMS finalized that products from manufacturers without an NDRA will lose Medicare Part B payment effective April 1, 2026. To implement this reimbursement change, these products' HCPCS codes will be assigned status indicator E1 under OPPS and ASC payment indicator B5, rendering them non-payable under Medicare in outpatient settings. CMS notes that upon the publication of the Final Rule, if a manufacturer immediately contacts CMS with the intent to enter into an NDRA, CMS will aim to maintain their separate payment for January 1, 2026. The current list of drugs manufactured without an NDRA is found in Table 116 (pg. 766) of the Final Rule.

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

In the CY 2025 OPPS Final Rule, CMS finalized 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. To implement the $10 add-on payment that begins on January 1, 2026, CMS finalized a new HCPCS C-code C9176 (Tc-99m from domestically produced non-HEU Mo-99, [minimum 50 percent], full cost recovery add-on, per study dose).[23] Hospitals can bill this add-on code if the hospital can certify that at least 50 percent of the Mo-99 in the Tc-99m generator to produce the Tc-99m was domestically produced Mo-99.

Payment for Skin Substitutes

To address this growth related to skin substitutes, CMS finalized, starting January 1, 2026, to separately pay for the provision of certain groups of skin substitute products as incident-to supplies when they are used during a covered application procedure paid under the PFS in the non-facility setting or under the OPPS.[24] CMS also finalized the proposal to update the rates for the skin substitute categories annually through rulemaking using the most recently available calendar quarter of ASP data, when available, to set the rates.[25]

For CY 2026, CMS finalized grouping skin substitute products that are not drugs or biologicals into three payment categories based on FDA regulatory classifications (PMAs[26], 510(k)s[27] and 361 HCT/Ps[28]) and assigned each category to a corresponding new APC.[29] CMS chose to finalize a single payment rate of $127.14/cm² for all three categories for CY 2026 using updated Q4 2024

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[23] In the Final Rule, CMS finalized policy related to domestically produced Tc-99m that are consistent with the Department of Energy, National Nuclear Security Administration's (DOE/NNSA's) recommendations.
[24] This final policy does not apply to biological products licensed under section 351 of the Public Health Service Act (PHSA), which will continue to be paid as biologicals under the ASP methodology.
[25] In the event ASP data is not available for a particular product, CMS will use the outpatient hospital Manufacturer's Unit Cost (MUC) data. If MUC is not available, CMS will use the product's Wholesale Acquisition Cost (WAC) or 89.6 percent of Average Wholesale Price (AWP) if WAC is also unavailable.
[26] PMA-approved wound care products generally are intended to go beyond a simple wound cover to provide some type of direct treatment effect.
[27] 510(k)-cleared devices are dressings intended only to cover and protect a wound, to absorb exudate, and to maintain appropriate moisture balance within the wound. They are not intended to act on the wound to mediate, facilitate, or accelerate wound healing. Their activity is typically limited to that of a physical covering or wrap. Also, CMS finalized grouping any skin substitutes authorized through the De Novo pathway with those cleared under 510(k)s.
[28] Registered 361 HCT/Ps generally are dressings intended only to cover and protect a wound and are not intended to act on the wound to mediate, facilitate, or accelerate wound healing. Their activity is typically limited to that of a physical covering or wrap.
[29] APC 6000 (PMA Skin Substitute Products); APC 6001 (510(k) Skin Substitute Products); and APC 6002 (361 HCT/P Skin Substitute Products).

claims data.[30] CMS plans to wait for cleaner, updated utilization patterns before possibly setting separate rates for each category. The full list of codes and their payment groupings are available in Addendum B on the CMS website.

CMS also finalized creating a new status indicator "S1" under the OPPS for CY 2026 and beyond to designate that skin substitute products are paid separately from associated procedure codes as add-on codes. Status indicator S1 is now the official OPPS designation for skin substitute products assigned to APCs 6000, 6001 and 6002, signaling their standalone payment status under OPPS.

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

For CY 2026, CMS finalized making permanent the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only), except for services that have a global surgery indicator of 010 or 090.[31,32]

Services That Will Be Paid Only as Inpatient Services

For CY 2026 and subsequent years, CMS finalized eliminating the Inpatient Only (IPO) list through a 3-year transition, completing the elimination by January 1, 2029, to allow providers time to prepare to furnish newly removed procedures on an outpatient basis, update their billing systems and gain experience with newly removed procedures eligible to be paid under either the IPPS or OPPS.[33] In the Final Rule, CMS notes that taking a service off the IPO list does not make outpatient care the default and providers can continue performing these procedures in either the inpatient or outpatient setting. CMS finalized beginning the elimination of the IPO list by removing 285 mostly musculoskeletal procedures. To support this transition of services being removed from the IPO and therefore available on an outpatient basis, CMS also finalized creating a Level 7 Musculoskeletal Procedures APC series for CY 2026 (APC 5117). The list of services removed from the IPO list for CY 2026 and the complete list of codes assigned to APC 5117 (Level 7 Musculoskeletal Procedures) are available in Addendum B on the CMS website.

Once a procedure is removed from the IPO list, it becomes subject to the 2-midnight rule, which allows Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) to review short-stay inpatient claims and issue denials.[34] However, CMS previously created an

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[30] A rate of $125.38/cm2 was originally proposed but for the Final Rule, CMS recalculated the payment using more recent Q4 2024 hospital outpatient claims volume and updated ASP/MUC data, which produced the slightly higher weighted-average cost.
[31] "Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable"
[32] Major surgeries (90-day post-operative period).
[33] The inpatient only (IPO) list identifies services for which Medicare will only make payments when the services are furnished in the inpatient hospital setting because of the nature of the procedure, the underlying physical condition of the patient or the need for at least 24 hours of postoperative recovery time or monitoring period before discharge. Currently, there are approximately 1,731 services on the IPO list and CMS annually reviews the IPO list to identify any services that should be removed from, or added to, the list, based on the most recent data and medical evidence available. CMS uses five specific criteria for assessing procedures for removal from the IPO list. The five criteria CMS uses are: 1. Most outpatient departments are equipped to provide the services to the Medicare population. 2. The simplest procedure described by the code may be furnished in most outpatient departments. 3. The procedure is related to codes that we have already removed from the IPO list. 4. A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis. 5. A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been proposed by us for addition to the ASC list.
[34] https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

indefinite exemption for any procedure removed from the IPO list on or after January 1, 2021, protecting these claims from site-of-service denials and RAC referrals.[35]

Changes to the Ambulatory Surgical Center (ASC)-Covered Procedures List (CPL)

For CY 2026, CMS finalized updates to the ASC CPL criteria, including moving the two safety standards to a new section of the criteria focused on physician judgment when determining the appropriate site of service.[36] CMS also finalized moving five, long-standing exclusion criteria to a new physician considerations section.[37] As a result of these changes, the remaining three exclusion criteria[38] are: procedures designated as IPO, procedures reported only with unlisted CPT codes and procedures otherwise excluded by statute.[39] CMS notes that because the IPO list is being phased out over three years starting in 2026, CMS would keep the IPO exclusion to maintain consistency during the transition, but noted that this criterion would no longer apply once a procedure is removed from the IPO list.

Further, CMS finalized adding a total of 547 procedures to the ASC CPL, including 276 codes identified as meeting the revised criteria, as well as 271 procedures that were removed from the IPO list. Of 44 procedures commenters suggested adding to the ASC CPL, CMS finalized adding 13 codes, including certain cardiac and diagnostic services.[40,41]

Medical Education

CMS finalized that accreditors may not require as part of accreditation, or encourage institutions to put in place Diversity, Equity and Inclusion programs that encourage unlawful discrimination based on race or other violations of Federal law beginning on January 1, 2026.

Additionally, in the Final Rule, CMS announced the closure of a hospital which initiates an application and selection process for redistributing its Indirect Medical Education (IME) and direct GME Full-Time Equivalent (FTE) resident slots.[42] CMS includes directions on applying for available slots in the Final Rule (pgs. 1506-1507) and indicates applications are due no later than February 19, 2026.

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[35] https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0
[36] The two safety standards are services that are not expected to pose significant safety risk in an ASC and not typically require active monitoring past midnight.
[37] § 416.166(c)(1)–(5)
[38] § 416.166(c)(6)–(8)
[39] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-416/subpart-F/section-416.166
[40] See Table 131 on pgs.1068-1079 of the Final Rule for the list of the additions to the ASC CPL list for CY 2026.
[41] See Table 132 on pgs.1079-1089 of the Final Rule for the list of the IPO list removals added to the ASC CPL list for CY 2026.
[42] Section 5506 of the Affordable Care Act allows CMS to redistribute residency slots when a teaching hospital closes, prioritizing hospitals in the same or nearby Core Based Statistical Area (CBSA) or state. www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1171otn.pdf

Quality Program Updates

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

Finalized Measure Changes

For the Hospital OQR and ASCQR Programs, CMS finalized policy to remove the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period/CY 2026 payment determination. Hospitals and ASCs that do not report their CY 2024 reporting period data for this measure would not be considered noncompliant with the measure for their CY 2026 payment determination and not be penalized for CY 2026 payments due to this measure.

Also, for the Hospital OQR, REHQR and ASCQR Programs, CMS finalized removal of the Hospital Commitment to Health Equity (HCHE) and Facility Commitment to Health Equity (FCHE) measures beginning with the CY 2025 reporting period/CY 2027 payment or program determination.[43] As a result, hospitals, REHs and ASCs that do not report their CY 2025 reporting period data for the HCHE or FHCE measure to CMS will not be considered noncompliant with the measure for purposes of their CY 2027 payment or program determination.

CMS also finalized policy to remove the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health process measures from the Hospital OQR, REHQR and ASCQR Programs beginning with the CY 2025 reporting period.[44]

Updates to the Extraordinary Circumstances Exception (ECE) Policy

Under the current ECE regulations, CMS grants exceptions to data submission deadlines and requirements for the Hospital OQR, REHQR and ASCQR Programs in the event of extraordinary circumstances beyond the control of a hospital, an REH or an ASC.[45] CMS finalized shortening the ECE request window from 90 to 60 calendar days after the event's occurrence, aligning with the policy finalized in the CY 2026 IPPS Final Rule. The request must be made in writing. CMS also finalized that the agency may grant an ECE to one or more hospitals, REHs or ASCs that have not requested an ECE if CMS determines that a systemic problem with a CMS data collection system directly impacted the ability to comply with a quality data reporting requirement or that an extraordinary circumstance has affected an entire region.

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[43] CMS estimates removal of these measures would alleviate an estimated annual burden of approximately 533 hours, at a cost of $29,347 across all participating hospitals; 6 hours, at a cost of $349, across all participating REHs; and 765 hours, at a cost of $42,121 across all participating ASCs.

[44] CMS estimates a total annual burden of 6,877,522 hours at a cost of $176,270,889 in the Hospital OQR Program (89 FR 94523 and 94524), 14,795 hours at a cost of f $379,188 in the REHQR Program (89 FR 94530 and 94531), and 729,045 hours at a cost of $18,685,423 in the ASCQR Program (89 FR 94534 and 94535), to screen all admitted patients in accordance with measure specifications for Screening for Social Drivers of Health and report the measure data. For Screen Positive Rate for Social Drivers of Health, CMS estimated a total annual burden of 533 hours at a cost of $29,347 in the Hospital OQR Program (89 FR 94524), 6 hours at a cost of $349 in the REHQR Program (89 FR 94531 and 94532), and 765 hours at a cost of $42,121in the ASCQR Program (89 FR 94535), to report the measure data.

[45] (42 CFR 419.46(e); 419.95(g); 416.310(d), respectively).

Hospital Outpatient Quality Reporting Program

Changes to the Hospital OQR Program Measure Set

Adoption of the Emergency Care Access & Timeliness 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

Due to growing concerns about the quality and timeliness of care in the hospital emergency department (ED), CMS finalized adoption of the Emergency Care Access & Timeliness eCQM.[46] CMS plans to monitor the burden on patients and providers and identify areas where challenges may persist and will publicly report the overall measure score and rates for the four numerator components, and the criteria-specific results regarding the age and mental health strata once the measure becomes mandatory. A full description of the finalized measure calculation is found on pgs.1198-1202 of the Final Rule.

Additionally, for the CY 2027 reporting period, CMS finalized the requirement that hospitals who voluntarily submit Emergency Care Access and Timeliness eCQM data could submit data for any quarter, up to all four quarters of data. Beginning with the CY 2028 reporting period/CY 2030 payment determination, CMS will require that hospitals report all four calendar quarters (one CY) of data to be submitted by May 15 in the year prior to the affected payment determination year.

Removals of the Median Time from ED Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) Measure[47] and the Left Without Being Seen Measure[48] Beginning With the CY 2028 Reporting Period/CY 2030 Payment Determination

The finalized Emergency Care Access & Timeliness eCQM will now serve as a replacement for these two existing chart-abstracted measures in the Hospital OQR. In the Final Rule, CMS notes that the numerator components[49] of the finalized Emergency Care Access & Timeliness eCQM measure overlap with the patient population and measure specifications of the Median Time for Discharged ED Patients measure and the Left Without Being Seen measure.

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[46] This measure specified for the hospital setting and calculates the proportion of four outcome metrics that quantify access to and timeliness of care in an ED setting against specified thresholds, including: (1) patient wait time – 1 hour; (2) whether the patient left the ED without being evaluated; (3) patient boarding time in the ED; (as defined by a Decision to Admit (order) to ED departure for admitted patients) – 4 hours; and (4) patient ED LOS (time from ED arrival to ED physical departure, as defined by the ED departure timestamp) – 8 hours.

[47] The Median Time for Discharged ED Patients measure assesses the time patients spent in the ED before being sent home, also known as ED throughput.

[48] The Left Without Being Seen measure assesses the percentage of patients who leave the ED without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA).

[49] Numerator component (2) overlaps with the Left Without Being Seen patient population, and numerator component (4) overlaps with the Median Time for Discharged ED Patients measure. In addition to capturing the same data elements as the Median Time for Discharged ED Patients and Left Without Being Seen measures, the Emergency Care Access & Timeliness eCQM measures boarding time in the ED, numerator component (3), and time from arrival to placement in a treatment room, numerator component (1), which are not currently captured by any other measure currently in the Hospital OQR Program measure set.

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/CY 2029 Payment Determination to Continue Voluntary Reporting in the CY 2027 Reporting Period and Subsequent Years

In the CY 2026 OPPS Final Rule, CMS finalized maintaining voluntary reporting of this measure beginning with the CY 2027 reporting period. CMS plans propose a date to begin mandatory reporting for this measure, most likely in the CY 2027 OPPS Proposed Rule.

Overall Hospital Quality Star Rating Modification to Emphasize the Safety of Care Summary

For CY 2026, CMS finalized a two-stage update to place greater weight on the Safety of Care group within the Overall Hospital Quality Star Rating, which summarizes publicly reported hospital quality measure results by assigning hospitals between one and five stars.[50]

In the first stage, CMS finalized an update limiting hospitals in the lowest quartile of Safety of Care (based on at least three measure scores) to a maximum of 4 stars out of 5 so that any hospital that is assigned 5 stars but has a lowest quartile Safety of Care score (based on at least three Safety of Care measures) would be reassigned to 4 stars in the CY 2026 Overall Hospital Quality Star Rating.[51] For the second stage of the methodology update, CMS finalized a reduction of the Overall Hospital Quality Star Rating of any hospital in the lowest quartile of Safety of Care (based on at least three measure scores) by 1 star, to a minimum 1-star rating for the 2027 Overall Hospital Quality Star Rating and later years.[52] Table 142 (pgs. 1333-1334) in the Final Rule gives a full impact assessment of these methodological changes on hospitals. CMS provides hospitals the opportunity to preview their Overall Hospital Quality Star Rating prior to publication. Hospitals have at least 30 days to preview their results, and if necessary, can reach out to CMS with questions.

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

In the Final Rule, CMS finalized a policy requiring hospitals to report on their Medicare cost report the median payer-specific negotiated charge with Medicare Advantage Organizations (MAOs) by MS-DRG beginning with cost reports ending on or after January 1, 2026.[53] CMS also finalized that, starting January 1, 2026, if a hospital's negotiated amount is based on a percentage or algorithm, the hospital must describe the formula in its machine-readable file (MRF) and report a new data element, the "median allowed amount," instead of the current "estimated allowed amount."[54] In the

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[50] Measures reported on the provider comparison tool on Medicare.gov that meet the criteria for inclusion in the Overall Hospital Quality Star Rating are organized into five measure groups: Safety of Care, Mortality, Readmission, Patient Experience (all of which include outcome measures) and Timely and Effective Care (which includes a selection of process measures).https://www.medicare.gov/care-compare/

[51] In the Final Rule, CMS estimates that using 2024 Overall Hospital Quality Star Rating data, implementing a cap of 4 stars in the lowest quartile of Safety of Care with at least three safety measures would result in 14 hospitals, out of 2,847 hospitals, receiving a lower Overall Hospital Quality Star Rating.

[52] In the Final Rule, CMS estimates that using 2024 Overall Hospital Quality Star Rating data, applying a 1-star reduction for all hospitals in the lowest quartile of Safety of Care with at least three safety measures would result in 459 hospitals, out of 2,847 hospitals, receiving a lower Overall Hospital Quality Star Rating beginning in CY 2027 and for later years.

[53] CMS had finalized a similar policy under the first Trump administration, but it was repealed under the Biden administration.

[54] The "median allowed amount" is defined as the median of the total allowed amounts the hospital has historically received from a third-party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to the date the MRF is posted.

Final Rule (pg.1468), CMS provides instruction on how to determine the weighted median of the payer-specific negotiated charges that the hospital negotiated with its MAOs, by MS-DRG.

Starting in FY 2029, CMS plans to calculate the median negotiated charge for each MS-DRG in a new market-based methodology to replace reliance on current hospital chargemaster gross charges and cost report data. According to CMS, the collection and reporting of median charges align with hospital price transparency requirements.

CMS stated it will make its analysis of the market-based data, including estimated payment impacts, available for public review before the methodology takes effect in FY 2029. If the data show more than a limited impact on MS-DRG weights, CMS will seek additional public input and remains open to adjusting the policy through future rulemaking.

Starting in FY 2029, CMS will use hospital disclosure data to calculate median negotiated charges for each MS-DRG, replacing reliance on gross charges and cost reports to better reflect resource use. This aligns with price transparency rules, adds definitions such as “median allowed amount” and will be publicly analyzed before implementation. If impacts are significant, CMS will seek input and adjust through future rulemaking. Hospitals are expected to begin reporting the required market-based data on cost reports for periods ending on or after January 1, 2026.

Price Transparency: Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

Consistent with a recent Executive Order and to better attain the goals articulated in previous hospital price transparency (HPT) rulemaking, CMS finalizes several modifications to current HPT requirements. While these new requirements are effective January 1, 2026, CMS is delaying enforcement of these requirements, except for the new changes related to civil monetary penalties (CMPs), to April 1, 2026, to give hospitals additional time to encode the new data elements and review their MRFs prior to making them public online.

New Data Elements and Reporting Requirements[55]

CMS finalized requiring hospitals to report new data elements when a standard charge is based on a percentage or algorithm.[56] These new elements are the median allowed amount (which would replace the estimated allowed amount data element), the 10th percentile and 90th percentile allowed amounts and the count of allowed amounts used to calculate the median, 10th and 90th percentile allowed amounts. To align with this proposal, the agency finalized adding definitions for

[55] CMS will provide technical guidance and examples of how to encode the new data elements on CMS Hospital Price Transparency – Data Dictionary GitHub Repository (https://github.com/CMSgov/hospital-price-transparency) and guidance on the HPT resources page on the CMS website (https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/resources).

[56] CMS estimates that hospitals will incur an additional one-time cost to update their processes and systems to (1) identify and collect new data elements and (2) encode the standard charge information for the newly proposed elements in the CMS standard template. This one-time burden estimate, as demonstrated in section “XXII. Collection of Information” of this proposed rule is 88,992hours for all hospitals (12 hours x 7,416 hospitals) at a cost of $10,840,708.80 ((7,416 hospitals × [($87.52 × 8 hours) + ($128.00 × 2 hours) + ($252.82 × 2 hours])

three new data elements, the “median allowed amount”,[57] the “tenth (10th) percentile allowed amount”[58] and the “ninetieth (90th) percentile allowed amount”.[59]

CMS finalized a requirement for hospitals to use EDI 835 ERA transaction data,[60] or an equivalent remittance source, to calculate and encode the allowed amounts. Additionally, CMS expects hospitals to use the most recent 12 months of data that are available to them. However, in the case where hospitals need additional time to pull or prepare the data before posting the MRF, hospitals may use data from up to 15 months prior to the date the file is posted to help ensure they have adequate data to encode the allowed amounts.

Requirement to Modify the MRF Affirmation Statement

CMS finalized policy to replace the current MRF affirmation statement requirement with a more detailed attestation statement within the MRFs, effective January 1, 2026. Beginning on this date, hospitals are required to attest that all applicable standard charge information is included and is true, accurate and complete as of the file’s date; all payer-specific negotiated charges that can be expressed in dollars are encoded; and for charges based on a percentage, algorithm or formula, hospitals must confirm that such methodology precludes the provision of a fixed dollar amount and that all necessary information has been provided to allow the public to derive the dollar amount. Additionally, hospitals must encode the name of the CEO, president or senior official responsible for overseeing the accuracy and completeness of the data.

CMS also finalized a requirement that if a hospital’s negotiated charge is based on a percentage or algorithm, the hospital must describe the formula and report the median allowed amount in dollars for the item or service. Hospitals must calculate this median using EDI 835 ERA transaction data, or an equivalent source of remittance data with the same information and include it in their MRF.[61] CMS illustrates an example outlining this process in the Final Rule (pgs. 1471-1472).

Requirement to Report Hospital National Provider Identifier (NPI) Information in the MRF

Stakeholders have reported that current requirements are inadequate to facilitate comparing hospital MRF data with other datasets that include hospital-related information and that a standard identifier would bolster these efforts. Therefore, CMS finalized an update to regulations to require hospitals, beginning January 1, 2026, to report a unique identifier, specifically their NPI(s), in their MRFs. Specifically, hospitals are required to report, in a newly created general data element in the

[57] “Median allowed amount” would be defined as the median of the total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated median fall between two observed allowed amounts, the median allowed amount is the next highest observed value.
[58] “Tenth (10th) percentile allowed amount” would be defined as the 10th percentile of the total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated percentile fall between two observed allowed amounts, the 10th percentile allowed amount is the next highest observed value.
[59] Ninetieth (90th) percentile allowed amount” would be defined as the 90th percentile of total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated percentile fall between two observed allowed amounts, the 90th percentile allowed amount is the next highest observed value.
[60] EDI 835 ERA transaction data is electronic transaction data that provides claim payment information that hospitals use to track and analyze their claims and reimbursement patterns, including any adjustments made to the claim such as denials, reductions, or increases to the amount charged, and expected patient co-pays, coinsurance or secondary coverage, would meet the requirement to calculate an allowed amount.
[61] Hospitals already calculate the median using data disclosed on their MRFs under hospital price transparency rules

MRF, any Type 2 NPI(s)[62] that has a primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit) and that is active as of the date of the most recent update to the standard charge information. CMS plans to include additional technical instructions in the CMS data dictionary and JSON schema in the Hospital Price Transparency – Data Dictionary GitHub Repository.[63]

Enforcement

CMS finalized an update, effective January 1, 2026, to the HPT regulations offering the amount of a civil monetary penalty (CMP) to be reduced by 35 percent should a hospital submit to CMS a written notice requesting to waive its right to a hearing within 30 calendar days of the date of the notice of imposition of the CMP. If a hospital waives its right to appeal a CMP and receives a 35 percent reduction, the hospital: (1) would not be eligible to receive a 35 percent reduction on any CMPs that result from the same instance(s) of noncompliance (that is, continuing violations); and (2) would waive its right to appeal CMPs for any such continuing violations. A hospital that meets the criteria to receive a reduction to the civil monetary penalty that had been imposed upon it must pay the CMP within 60 calendar days after the date of the notice of imposition of a CMP from CMS.

What's Next?

The OPPS tables for the CY 2026 Final Rule are available on the CMS website. Most provisions in the Final Rule go into effect January 1, 2026. CMS plans to postpone enforcement of the hospital price transparency requirements to April 1, 2026, to give hospitals additional time to meet the new requirements. Vizient's Office of Public Policy and Government Relations is available to answer questions about provisions in the Final Rule. Please reach out to Jenna Stern, Vice President, Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.

[62] Healthcare providers who are individuals are assigned a Type 1 NPI and healthcare providers that are organizations are assigned a Type 2 NPI.
[63] Available at https://github.com/CMSgov/hospital-price-transparency