CMS' CY26 OPPS Final Rule

Top Payment and Revenue Implications:

1. OPPS Rate Update (+2.6%)

- Raises total OPPS payments by ~$8 billion nationally.
- Offset by ongoing penalties for OQR noncompliance.
- Net impact varies widely by service mix and site-of-service exposure.

2. Off-Campus Site Neutral Payment Policy (High Impact)

- Excepted off-campus PBD drug administration services shift to PFS-equivalent rates.
- CMS cites Section 603 (BBA 2015) and SSA §1833(t)(2)(F) as authority.
- Major exposure for infusion, oncology, rheumatology, and hospital-acquired practices.

3. 340B Remedy Offset (–0.5%)

- Permanent reduction to OPPS conversion factor for eligible hospitals.
- Exempts hospitals that enrolled in Medicare after Jan 1, 2018.

Star Ratings Safety Weighting

- Lowest-quartile safety hospitals capped at 4 stars in 2026 and reduced by one star in 2027.
- Reputational and payer contracting implications.

Hospital Outpatient and REH Quality Reporting

- New emergency access eCQM mandated; older ED and CT measures removed.
- Rural Emergency Hospitals must adopt new reporting standard by 2027.

Price Transparency Expansion

- Requires reporting of pricing percentiles plus NPIs, counts, and CEO attestation.
- Enforcement begins April 1, 2026, with expanded audit and public posting authority.

ASC-Focused Provisions

- ASC payments increase 2.6% and continue to follow hospital market basket.
- 547 procedures added to ASC eligible list, accelerating migration.
- Separate payment for skin substitutes at $127.14 under new APC groupings.

Cross-Setting Policies

- COVID-19, SDOH, and health equity measures removed across programs.
- Virtual direct supervision permanently allowed via audio-video.
- Nationwide drug acquisition cost survey begins CY 2026 for CY 2027 reform.
- Market-based MS-DRG weighting requires negotiated charge reporting beginning in 2026; implemented in FY 2029.

SECTION 1 — HOSPITALS

OPPS Payment Update

OPPS rates increase 2.6% for CY 2026, raising total payments by roughly $8 billion, with hospitals still subject to the 2% penalty for failing OQR reporting requirements. The update reflects a 3.3% market basket offset by a 0.7% productivity adjustment, and CMS estimates total OPPS payments will reach approximately $101.0 billion. CMS also notes continued implementation of wage index updates, cancer hospital adjustments, and budget neutrality factors affecting final payment levels.
Pages 8–9

Phase-Out of IPO List

CMS begins a three-year elimination of the IPO list, removing 285 procedures in CY 2026 while allowing them to be paid under either IPPS or OPPS. CMS states this phased approach will allow hospitals to adapt clinical workflows, billing systems, and postoperative monitoring pathways. Public commenters were divided, with some calling for slower removal pacing and others preferring immediate full elimination.
Pages 10 and 885

Two-Midnight Rule Exemptions

Procedures newly removed from the IPO list remain exempt from Recovery Audit Contractor site-of-service claim denials until outpatient billing dominates. CMS also clarifies that these exemptions apply to RAC referrals and persistent noncompliance audits during the transition. A regulatory clarification at 42 CFR 412.3(d)(2) is finalized to improve interpretation consistency.
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This means:

1. When CMS removes a procedure from the Inpatient Only (IPO) list, hospitals are newly allowed to bill it in either the inpatient setting (IPPS) or outpatient setting (OPPS).
2. For a temporary period, Medicare will NOT allow auditors to deny claims on the grounds that the procedure “should have been performed outpatient instead of inpatient.”
3. This protection continues until CMS sees that most hospitals are billing the procedure outpatient, demonstrating that outpatient care has become the standard.
4. Once outpatient billing becomes the predominant pattern, auditors may begin denying inpatient claims for that procedure if the patient did not meet medical necessity for inpatient status.

Hospital Star Ratings Safety Weighting

CMS implements a two-step methodology that caps hospitals in the lowest quartile of Safety of Care at 4 stars in 2026 and reduces ratings by one star starting in 2027. CMS explains that hospitals could previously achieve high overall ratings despite poor safety results, undermining consumer confidence. The agency states the new approach prioritizes risk prevention for patients and healthcare workers and aligns with transparency objectives.
Pages 11–12

Hospital Outpatient Quality Reporting Changes

CMS adopts the Emergency Care Access & Timeliness eCQM with voluntary reporting in 2027 followed by mandatory reporting in 2028/2030 payment determination. Two ED timing measures are removed, and a CT radiation dose measure is shifted to voluntary status to reduce reporting burden. CMS states the modifications better reflect meaningful emergency care outcomes.
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REHQR Updates (Rural Emergency Hospital Quality Reporting)

REHs must report the Emergency Care Access & Timeliness measure beginning with the CY 2027 reporting period. CMS allows REHs to choose between this new measure and an ED discharge timing metric during transition to reduce operational disruption. CMS notes that the change supports improved emergency performance visibility in rural settings.
Page 11

GME Accreditation Non-Discrimination

Accreditation bodies are prohibited from using criteria based on protected classifications or intentional proxies. CMS states that the change aligns accreditation oversight with federal civil rights requirements. The rule applies beginning January 1, 2026, and aims to ensure equitable program participation and residency placement.
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Off-Campus Site Neutral Payment Policy

Under the off-campus site neutral payment policy, drug administration services performed in excepted off-campus PBDs will now be reimbursed at Physician Fee Schedule–equivalent rates rather than OPPS rates. CMS explains that this change is necessary to address growth in service shifting to higher-paying excepted off-campus settings, which the agency asserts increases Medicare expenditures without demonstrated increases in clinical complexity. The policy is explicitly framed as a continuation of Congressional intent to align off-campus payments with physician office levels to reduce incentives for hospital acquisition of physician practices. CMS also notes that it will monitor claim volume trends to determine whether additional services should be brought under site neutral alignment in future rulemaking

cycles. Rural Sole Community Hospitals are exempt due to access preservation concerns.
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What is the legal rationale CMS is using to make this change?
CMS is reducing payment for drug administration services furnished in excepted off-campus provider-based departments by paying them at Physician Fee Schedule–equivalent rates instead of OPPS rates. The agency cites Congressional language in Section 603 of the Bipartisan Budget Act of 2015**,** which directed that most off-campus services should not receive OPPS payment, and pairs it with its authority under SSA §1833(t)(2)(F) to establish payment methods that control the growth of OPPS service volume. CMS argues that higher OPPS reimbursement has driven unnecessary migration of drug administration services into off-campus hospital settings without corresponding increases in patient acuity, and therefore the new policy aligns payments with care setting while reducing Medicare spending. As a result, hospitals with sizable off-campus infusion or oncology drug administration programs will experience material revenue reductions beginning in CY 2026, while payers and Medicare beneficiaries will realize associated savings.

340B Remedy Offset

CMS applies a 0.5% reduction to the OPPS conversion factor to offset prior higher payments for non-drug services during 2018–2022. Hospitals that enrolled in Medicare after January 1, 2018 remain exempt from the adjustment. CMS emphasizes that the reduction is permanent and required to maintain budget neutrality.
Pages 13–14

Hospital Price Transparency Enhancements

Hospitals must report 10th percentile, median, and 90th percentile allowed amounts, as well as counts, NPIs, and CEO/executive attestation. CMS will begin enforcement April 1, 2026 but offers a 35% CMP reduction for hospitals waiving administrative appeal. CMS asserts the upgrades will increase comparability with payer transparency data and improve pricing clarity for purchasers. CMS also requires hospitals to conform to a standardized data schema that aligns machine-readable files with insurer Transparency in Coverage formats, which will require significant retooling of internal pricing systems and contract mapping. The rule expands auditing authority, allows CMS to publicly post noncompliance notices, and requires hospitals to correct deficiencies within a shortened remediation window. CMS also signals that future rulemaking may mandate full charge-to-allowed crosswalks and payer-specific volume disclosures, increasing strategic exposure for high-rate systems.
Pages 15–16 and 1368–1369

SECTION 2 — AMBULATORY SURGICAL CENTERS (ASCs)

ASC Payment Update

CMS extends use of the hospital market basket for ASC rate setting through CY 2026, resulting in a 2.6% increase. Total ASC payments are projected to increase by $450 million. CMS states this approach continues to account for pandemic-era utilization distortion.
Pages 8–9

Expansion of ASC Covered Procedures List

CMS removes five exclusion criteria and reclassifies them as clinical judgment considerations for physicians. A total of 547 procedures are added, including those newly removed from the IPO list. CMS indicates the change supports site-of-care flexibility and migration for musculoskeletal and other procedures.
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ASCQR Program Update

CMS declines to finalize the proposed patient-reported Information Transfer PRO-PM. Commenters raised feasibility and burden objections. CMS states it will continue stakeholder engagement before reconsidering adoption.
Pages 11–12

ASC Skin Substitute Payment Impacts

ASCs receive separate payment based on new APC categories tied to FDA approval pathway. The initial rate of $127.14 applies to products under APCs 6000–6002. CMS states the approach aligns ASC and OPPS treatment of these items.
Pages 14 and 716–718

SECTION 3 — CROSS-SETTING / SYSTEM-WIDE

Cross-Program Quality Measure Removals

CMS removes COVID-19 vaccination, SDOH screening, positive SDOH, and health equity measures across OQR, REHQR, and ASCQR. CMS states the measures either reached saturation or required refinement. Stakeholders generally supported burden reduction.
Pages 10–11

PHP/IOP Payment Methodology

CMS bases CMHC PHP and IOP payment rates on 40% of hospital-based rates to correct cost inversion patterns. CMS explains the adjustment stabilizes payments and aligns with comparative resource structures. The change affects CMHCs paid under OPPS and expands their participation scope.
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Drug Acquisition Cost Survey

CMS will survey all OPPS hospitals on drug acquisition costs beginning early CY 2026. The policy follows Executive Order 14273 to align acquisition cost measurement with policy reform. Results are intended to influence CY 2027 drug payment rates.
Pages 12–13

Virtual Direct Supervision

CMS permanently allows real-time audio-video supervision for PR, CR, ICR, and most diagnostic services. Audio-only supervision remains prohibited. CMS states the change reflects telehealth utilization trends and maintains clinical oversight integrity.
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Skin Substitute Payment Reform

CMS establishes separate payment for skin substitutes based on FDA regulatory pathway and introduces status indicator S1. The payment rate of $127.14 applies across settings. CMS notes this policy reduces administrative inconsistency and aligns payments with product characteristics.
Pages 14 and 716–718

Market-Based MS-DRG Weighting

Hospitals must report median payer-specific negotiated charges by MS-DRG beginning with CY 2026 cost reports. CMS will use these data to calculate market-based MS-DRG weights beginning FY 2029. The agency estimates 60,760 burden hours nationally for data collection.
Pages 14–15