Illinois Health and Hospital Association

RULE SUMMARY

DECEMBER 2025

MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE

Overview and Resources

On Nov. 21, 2025, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2026 final rule for the Medicare Outpatient Prospective Payment System (OPPS). The final rule includes updates to the Medicare fee-for-service OPPS payment rates based on changes set forth by CMS and those previously adopted by Congress. In addition to the regular updates to wage indexes and market basket, the policies being finalized in this rule include, but are not limited to:

- Updating Ambulatory Payment Classification (APC) groups and weights;
- Updating the 340B Remedy reduction to the OPPS conversion factor;
- Eliminating the Inpatient-Only (IPO) list;
- Updating Overall Hospital Quality Star Rating methodology;
- Updating requirements for the Hospital Outpatient Quality Reporting (OQR) Program;
- Additional payments for non-opioid treatment; and
- Updating payment rates and policies for Ambulatory Surgical Centers (ASCs).

A summary of the major hospital OPPS sections of the final rule is provided below. Program changes will be effective for discharges on or after Jan. 1, 2026, unless otherwise noted. CMS estimates an increase of $1.77 billion in OPPS payments for CY 2026 over CY 2025, prior to the application of the 340B remedy offset. For providers subject to the 340B remedy offset, CMS estimates a $275 million reduction in payments in CY 2026, resulting in a net increase of approximately $1.495 billion for the year.

The finalized rule and other resources related to the OPPS are available on the CMS website. An online version of this final rule is available here.

Comments are due to CMS by Jan. 20, 2026, and can be submitted electronically here by using the website's search feature for "CMS-1834-FC".

OPPS Payment Rates

CMS is adopting the use of CY 2024 claims data and CY 2023 Healthcare Cost Report Information System (HCRIS) data for CY 2026 OPPS rate setting.
The table below shows the final CY 2025 conversion factor compared to the finalized CY 2026 conversion factor.

	Final CY 2025	Final CY 2026	Percent Change
OPPS Conversion Factor	$89.169	$91.415 (proposed at $91.747)	+2.52%
OPPS Conversion Factor with 340B Remedy Offset	$89.169	$90.967 (proposed at $89.958)	+2.02%

The following table provides details of the finalized annual updates to the CY 2026 conversion factor.

Final CY 2026 Update Factor Component	Change to OPPS Conversion Factor
Market Basket Update	+3.30% (proposed at +3.2%)
Affordable Care Act (ACA)-Mandated MB Productivity Adjustment	-0.70 percentage points (PPTs) (proposed at -0.8 PPTs)
Wage Index Budget Neutrality (BN) Adjustment	-0.10% (proposed at +1.16%)
Wage Index 5% Stop Loss and Transitional Exception BN	-0.05% (proposed at -0.45%)
Pass-through Spending	+0.07% (proposed at -0.22%)
Cancer Hospital BN Adjustment	0.00% (as proposed)
Outlier BN Adjustment	0.00% (as proposed)
Overall Final Rate Update	**+2.52% (proposed at +2.89%)**
340B Remedy Offset	-0.49% (proposed at -1.95%)
Overall Final Rate Update with 340B Remedy Offset	**+2.02% (proposed at +0.88%)**

Payment adjustments for Non-Drug Items and Services as a Result of the 340B Payment Policy

The 340B Drug Pricing Program allows certain hospitals to purchase outpatient drugs at discounted prices. From CY 2018 to CY 2022, CMS reduced payments for 340B-acquired drugs from Average Sales Price (ASP)+6% to ASP-22.5% and redistributed savings to increase payments for non-drug items and services under the OPPS.

The Supreme Court ruled in *Bridgeport Hospital, et al., v. Becerra* that the payment reductions for 340B drugs were unlawful because CMS had not conducted a survey of hospital acquisition costs. In turn, CMS revised the payment policy to pay for 340B drugs at ASP+6% in a single-lump sum payment. To recoup the $7.8 billion increase that was made for non-drug items and services from CY 2018 to CY 2022, CMS adopted an annual prospective payment reduction of 0.49 percentage points (PPT) to the OPPS conversion factor in the 340B Final Remedy Rule that was to start in CY 2026. Recoupment was estimated to take approximately 16 years.

CMS did not finalize the proposed increase to the annual reduction for non-drug items and services from 0.49 PPT to 2.0 PPTs. Instead, CMS will continue applying the existing 0.49 percentage point annual reduction. This policy will exclude hospitals that enrolled in Medicare after Jan. 1, 2018. However, CMS is anticipating a larger percent reduction (such as 2 PPT or other reduction greater than 0.49 PPT) beginning in CY 2027.

Payment Increase for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs)

CMS is finalizing the continuation of the 7.1% budget neutral payment increase for rural SCHs and EACHs. This payment add-on excludes separately payable drugs, biologicals, brachytherapy sources, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. CMS will maintain this for future years until data supports a change to the adjustment.

Outlier Payments

To maintain total outlier payments at 1% of total OPPS payments, CMS used CY 2024 claims to calculate an estimated final outlier fixed-dollar threshold of $6,225 for CY 2026 (proposed at $6,450). This is a 22.2% decrease compared to the current threshold of $8,000. Outlier payments will continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiplier threshold and the fixed-dollar threshold are met.

Wage Index and Labor-Related Share

As in past years, CMS will continue to use federal fiscal year (FFY) 2026 IPPS wage indexes, including all reclassifications, add-ons, and rural floors to be applied to the labor-related share of CY 2026 OPPS payments in a budget neutral manner.

CMS applies a 5% cap on any decrease in the hospital wage index, compared to the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner nationally. This also means that if a hospital's prior wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the hospital's capped wage index in the prior year. Lastly, a new hospital will be paid the wage index for the area in which it is geographically located for its first full or partial year with no cap applied, because a new hospital will not have had a wage index in the prior year. CMS is finalizing a budget neutrality factor of 0.9995 for the impact of the 5% cap on wage index decreases.

As described below, CMS is aligning the OPPS wage index with the IPPS wage index. CMS notes that because the CY 2025 OPPS wage index was different than the FFY 2025 IPPS wage index, using the FFY 2026 IPPS wage index for CY 2026 OPPS wage index will result in decreases greater than 5% to some hospitals' wage indexes under the OPPS.

Separately, CMS is finalizing a wage index and labor-related share budget neutrality factor of 0.9990 for CY 2026 to ensure that aggregate payments made under the OPPS are not greater or less than will otherwise be made if wage index adjustments had not changed.

The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2026, CMS is continuing to use a labor-related share of 60%.

Addressing Wage Index Disparities Between High and Low Wage Index Hospitals

In the FFY 2020 IPPS final rule, CMS made a variety of changes to reduce the disparity between high and low wage index hospitals. Hospitals with a wage index value in the bottom quartile of the nation would have that wage index increased by a value equivalent to half of the difference between the hospital's post-rural floor, post-reclassification wage index and the 25th percentile wage index value across all hospitals. As adopted, this policy was to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. In the FFY 2025 final rule, CMS adopted to continue this policy for at least three more years, beginning in FFY 2025, in order for sufficient wage data from after the end of the COVID–19 Public Health Emergency to become available.

This policy was subject to litigation (*Bridgeport Hospital, et al., v. Becerra*) in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered additional briefing on an appropriate remedy. On July 23, 2024, the U.S. Court of Appeals for the D.C. Circuit affirmed the lower court's ruling, holding that this policy for FFY 2020 was unlawful and that CMS had no

statutory authority to issue it. As a result, the court ordered that the rule be vacated and that hospitals affected by the budget neutrality adjustment are entitled to back-payments, including interest.

At the time, CMS believed that their statutory authority in the OPPS setting differed from the IPPS setting and therefore in the CY 2025 OPPS final rule, CMS adopted to continue the policy that hospitals with a wage index value in the bottom quartile of the nation will have their OPPS wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals. CMS acknowledged the differences between the OPPS and IPPS wage index values for FFY 2025 and noted their intentions to explore options to realign the wage index values in future rulemaking.

For CY 2026 and subsequent years CMS has finalized the realignment of the IPPS and OPPS wage index values and adopted the elimination of the low wage index hospital policy under the OPPS. In order "to mitigate short-term instability and payment fluctuations that can negatively impact hospitals consistent with principles of certainty and predictability under the prospective payment systems," CMS has adopted a transitional payment exception for CY 2026. The transitional payment exception policy will apply to hospitals that benefitted from the CY 2024 low wage index hospital policy. If a hospital's CY 2026 wage index decreases by more than 9.75% from its CY 2024 wage index, the transitional payment exception will be set to 90.25% of the CY 2024 wage index. The transitional payment exception will be applied after the application of the 5% cap and will be budget neutral under the OPPS.

Updates to the APC Groups and Weights

CMS is required by law to review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.

The finalized payment weights and rates for CY 2026 are available in Addenda A and B within Addendum P of the final, and they are here.

For CY 2026, CMS is adopting to recalibrate payment weights for services furnished on or after Jan. 1, 2026, and before Jan. 1, 2027, using the CY 2024 claims data.

The table below, based on Addendum A, shows the update in the number of APCs per category from CY 2025 to CY 2026:

APC Category	Status Indicator	Final CY 2025	Final CY 2026
Pass-Through Drugs and Biologicals	G	107	117
Pass-Through Device Categories	H	17	19
Non-opioid Medical Devices For Post-Surgical Pain Relief	H1	5	13
OPD Services Paid through a Comprehensive APC	J1	71	73
Observation Services	J2	1	1
Non-Pass-Through Drugs/Biologicals	K	490	526
Non-Opioid Drugs and Biologicals For Post-Surgical Pain Relief	K1	5	5
Partial Hospitalization	P	8	8

Blood and Blood Products	R	41	41
Procedure or Service, No Multiple Reduction	S	80	67
Slom Substitute Products	S1	-	3
Procedure or Service, Multiple Reduction Applies	T	29	29
Brachytherapy Sources	U	17	17
Clinic or Emergency Department Visit	V	11	11
New Technology	S/T	112	112
Total		994	1042

Calculation of Cost-To-Charge Ratios (CCRs)

For CY 2026, CMS will continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs. CMS is adopting to exclude cost report lines for non-standard cost centers in OPPS rate setting when hospitals have reported this data on cost report lines that do not correspond to the cost center number.

Blood and Blood Products

For CY 2026, CMS will continue its policy to establish payment rates for blood and blood products using a blood-specific CCR methodology.

Brachytherapy Sources

For CY 2026, CMS will continue its policy to use the costs derived from the most recent set of claims data (CY 2024) to set payment rates for brachytherapy sources. With the exception of brachytherapy source C2645 (brachytherapy planar source, palladium-103, per square millimeter) and low volume brachytherapy APCs, CMS is adopting to base payment rates on the geometric mean unit costs (MUCs) for each source. For CY 2026 and future years, CMS is also finalizing to pay for the stranded and nonstranded 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 nonstranded prospective payment rate for such sources, respectively, on a per-source basis.

For CY 2026, CMS is designating six brachytherapy APCs as low volume APCs.

Radioisotopes Derived from Non-Highly Enriched Uranium (Non-HEU) Sources

Historically, most of the supply of molybdenum (Mo-99) (used in the creation of Technetium-99m [Tc-99m], a commonly used diagnostic imaging radioisotope) used in the U.S. is sourced from reactors outside of the country using highly enriched uranium. In the CY 2025 OPPS final rule, CMS adopted a new add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 to eliminate reliance on these foreign reactors.

In this final rule, CMS is adopting several criteria for classifying a TC-99m Radiopharmaceutical dose as domestically produced, including defining:

- Domestically produced dose of Tc-99m: A dose of Tc-99m generated from domestically produced Mo-99.
- Domestically produced Mo-99: Mo-99 that was both irradiated and processed in the U.S.
- Irradiated: The process of bombarding a uranium or molybdenum target with radiation in order to produce Mo-99, and to specify that irradiation is typically performed with a nuclear reactor or particle accelerator.

- Processed: In this context, processed refers to the purification of Mo-99 from irradiated material.

Additionally, CMS is adopting a new HCPCS C-code C9176 (Tc-99m from domestically produced non-HEU Mo-99, [minimum 50%], full cost recovery add-on, per study dose), effective Jan. 1, 2026. Hospitals will be able to report the new HCPCS C-code C9176 once per dose, along with any diagnostic scans furnished using Tc-99m derived from domestically produced Mo-99. Hospitals can bill the add-on code if they can certify that at least 50% of the Mo-99 in the Tc-99m generator to produce the Tc-99m was domestically produced Mo-99.

Comprehensive APCS

A Comprehensive APC (C-APC) provides all-inclusive payments for certain procedures and covers payment for all applicable Part B services that are related to the primary procedure, including items currently paid under separate fee schedules. Each C-APC encompasses diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; coded and un-coded services and supplies used during the service; outpatient department services delivered by therapists as part of the comprehensive service; durable medical equipment as well as the supplies to support that equipment; and any other components reported by HCPCS codes that are provided during the comprehensive service.

The costs of blood and blood products are included in the C-APCs when they appear on the same claim as those services assigned to a C-APC. The C-APCs do not include payments for services that are not covered by Medicare Part B, nor those that are not payable under OPPS, such as: certain mammography and ambulance services; brachytherapy sources; pass-through drugs and devices; charges for self-administered drugs; certain preventive services; and procedures assigned to a New Technology APC either included on a claim with a "J1" or included on a claim with a "J2" indicator and packaged into payment for comprehensive observation services assigned to status indicator "J2".

For CY 2026 and subsequent years, CMS is adopting to exclude payment for cell and gene therapies from C-APC packaging, listed in Table 3, into the payment for the primary C-APC service on the same claim when those cell and gene therapies are not functioning as integral, ancillary supportive, dependent, or adjunctive to the primary C-APC service. CMS is also adopting that products on this list with a pass-through status expiring in CY 2026 will be excluded from C-APC packaging after their pass-through status expires, which can be found in Table 105.

CMS is required to pay non-opioid pain relief drugs and devices separately instead of packaging them into C-APCs. The exclusion applies only to services furnished from Jan. 1,2025 through Dec. 31,2027. Qualifying products must have an FDA approved indication for postoperative or regional analgesia and evidence showing they reduce or replace opioid use. Products that do not meet these criteria will remain packaged under the standard C-APC payment policy.

Each year CMS reviews and revises the services within each APC group and APC assignments under the OPPS. CMS is not converting any standard APCs to C-APCs. The finalized CY 2026 C-APCs can be found in Table 4.

Composite APCS

Composite APCs are another type of packaging to provide a single APC payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are six composite APCs:

- Mental Health Services (APC 8010).
- Multiple Imaging Services (APCs 8004, 8005, 8006, 8007, and 8008).

For CY 2026, CMS is will continue its policy that when the aggregate payment for specified mental health services provided by a hospital to a single beneficiary on a single date of service exceeds the maximum per diem payment rate for partial hospitalization services, those services will continue to instead be paid through composite APC 8010. In addition, CMS is finalizing that the payment rate for composite APC 8010 will continue to be set to that established for APC 5864 (four or more hospital-based partial hospitalization services per day) as it is the maximum partial hospitalization per diem payment rate for a hospital.

CMS is continuing its current composite APC payment policies for multiple imaging services from the same family and on the same date for CY 2026. Under this methodology, all qualifying imaging procedures within the same family are consolidated into a single composite APC payment. Table 5 lists the final HCPCS codes that will be subject to the multiple imaging procedure composite APC policy, their respective families, and each family's geometric mean cost.

Universal Low Volume APCS Payment Policy

For CY 2026, CMS is continuing the universal low-volume APC payment methodology for services assigned to New Technology, clinical, and brachytherapy APCs with fewer than 100 single claims. This policy uses the highest of the geometric mean, arithmetic mean, or median based on up to four years of claims data to set the payment rate for the APC.

The finalized 11 low volume APCs for CY 2026 can be found in Table 42.

Payment for Medical Devices With Pass-Through Status

There are currently 20 device categories that are eligible for pass-through payment:

- C1826 – Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system
- C1827 – Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller
- C1747 – Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)
- C1600 – Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)
- C1601 – Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)
- C1602 – Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)
- C1603 – Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)
- C1604 – Graft, transmural transvenous arterial bypass (implantable), with all delivery system components
- C1605 – Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation
- C1606 – Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope
- C8000 - Support device, extravascular, for arteriovenous fistula (implantable)

- C1735 - Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components
- C1736 - Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components
- C1737 - Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)
- C1738 - Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device
- C1739 - Tissue marker, probe detectable any method (implantable), with delivery system
- C9610 - Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)
- C1740 - Leadless electrode, transmitter, battery (all implantable),for sequential left ventricular pacing
- C1741 - Anchor/screw for bone fixation, absorbable (implantable)
- C1742 - Pressure monitoring system, compartmental intramuscular (implantable), continuous, including all components (e.g., introducer, sensor), excludes mobile (wireless) software application

CMS has received eight applications for device pass–through payment applications by the March 3, 2025, quarterly deadline, two were approved for pass-through payment:

- VasQ
- SCOUT MD™ Surgical Guidance System

Device-Intensive Procedures

CMS defines device-intensive APCs as those procedures which require the implantation of a device and are assigned an individual HCPCS code-level device offset of more than 30% of the procedures mean cost, regardless of APC assignment. In the CY 2025 final rule CMS modified their proposed device policy for new HCPCS codes for procedures that require the implantation/insertion of a single-use device meeting CMS' device-intensive requirements. If the procedures lack claims data CMS will apply a default device offset percentage that is the greater of 31% or the APC's devices offset percentage, when claims data is unavailable. CMS also updated its device edits policy so that procedures that cannot use the "CG" modifier will have their offset percentage calculated based on hospital claims that include a device code. Additionally, claims data from procedures with a status indictor "EI" during the rate setting year will be excluded and the process for applying device offset percentages will be refined to use claims data from predecessor codes' annually until successor code data is available. CMS is finalizing to continue these policies for CY 2026.

The full list of the final CY 2026 device-intensive procedures can be found in Addendum P of this final rule

Device Edit Policy

In CY 2025 OPPS final rule CMS adopted device edit policy with modifications to apply the device edit policy permanently once a procedure is designated as a device-intensive procedure in a given year. Additionally, CMS also adopted a policy to reinstate the device edits policy for procedures that have been device-intensive since CMS began assigning device-intensive status at the HCPCS code level on or after Jan. 1, 2017. CMS will continue the device edit policy without modifications for CY 2026.

Payment Adjustment for No Cost/Full Credit and Partial Credit Devices

For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital receives a credit from the manufacturer. The offset can be 100% of the device amount when a hospital attains the device at no cost or receives a full credit from the manufacturer; or 50% when a hospital receives partial credit of 50% or more. CMS determines the procedures to which this policy applies, using three criteria:

- All procedures must involve implantable devices that will be reported if device-insertion procedures were performed;
- The required devices must be surgically inserted or must be implanted devices that remain in the patient's body after the conclusion of the procedure (even if temporarily); and
- The procedure must be device-intensive (devices exceeding 30% of the procedure's average cost).

For CY 2026, CMS is maintaining the no cost/full credit and partial credit device policies.

Payment for Drugs, Biologicals and Radiopharmaceuticals

CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold. CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved in order to grant a pass-through period as close to a full three years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

For CY 2026 and subsequent years CMS is finalizing to use the same methodology finalized in CY 2025 to calculate the per day costs for diagnostic radiopharmaceuticals. Consistent with methodology and practices, CMS will update the diagnostic radiopharmaceutical packaging threshold of $630 to $655 for CY 2026. In addition, CMS is also adopting to continue to pay radiopharmaceuticals with per day costs above the diagnostic radiopharmaceutical packaging threshold, based on their arithmetic MUC, derived from CY 2024 claims data.

Separately for CY 2026, CMS is adopting a packaging threshold of $140. Drugs, biologicals, and radiopharmaceuticals (excluding diagnostic radiopharmaceuticals) that are above the $140 threshold are paid separately, using individual APCs, and those below the threshold are packaged; the baseline payment rate for CY 2026 is the ASP+6%. Separately payable drugs and biological products that do not have pass-through status are to be paid wholesale acquisition cost (WAC)+3%, instead of WAC+6%.
For CY 2026, CMS is finalizing to continue paying for blood clotting factors and therapeutic radiopharmaceuticals without pass-through payment status at ASP+6%. If ASP data are not available, payment instead will be made at WAC+3%; or 95% of average wholesale price (AWP) if WAC data are also not available.

For CY 2026 and subsequent years, for those HCPCS codes for drugs, biologicals and therapeutic radiopharmaceuticals that are impacted by the updated drug packaging threshold, CMS is adopting:

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2025 and that are finalized for separate payment in CY 2026, and that then have per day costs equal to or less than the CY 2026 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2026 final rule, would continue to receive separate payment in CY 2026.

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2025 and that are finalized for separate payment in CY 2026, and that then have per day costs equal to or less than the CY 2026 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2026 final rule, would remain packaged in CY 2026.
- HCPCS codes for drugs, biologicals, and radiopharmaceuticals for which we finalized packaged payment in CY 2026 but that then have per-day costs greater than the CY 2026 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2026 final rule, would receive separate payment in CY 2026.

For CY 2026, CMS is finalizing to continue to pay for non-pass-through diagnostic radiopharmaceuticals that are separately payable. CMS will continue to use MUC data for radiopharmaceuticals that are finalized as separately payable due to their cost exceeding the per-day threshold.

Additionally, CMS will continue the policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis for HCPCS codes that describe the same drug or biological but different dosages. CMS is also adopting this policy to apply to diagnostic radiopharmaceuticals.
As there are often HCPCS codes for new drugs or biologicals that have received marketing approval, but for which there is no sales data available, the affected drugs and biologicals are assigned a non-payable indicator.

For separately payable drugs and biologicals for which CMS does not provide a payment rate, CMS finalized in the CY 2025 OPPS final rule that Medicare Administrative Contractors (MACs) will calculate the payment based on provider invoices (net acquisition cost, less any rebates, chargebacks, or post-sale concessions). MACs will use the invoice to determine that the drug is not policy-packaged, and that the per-day cost is above the threshold packaging amount, as applicable. For CY 2026 CMS is adopting to clarify that CMS will determine whether the drug is not policy packaged, and the MAC will continue to determine whether the per-day cost is above the threshold packaging amount.

Lastly, CMS states that the pass-through status will expire by Dec. 31, 2025 for 57 drugs and biologicals, listed in Table 104; by Dec. 31, 2026 for 41 drugs and biologicals listed in Table 105; and will continue/establish pass-through status in CY 2026 for 41 drugs and biologicals shown in Table 106.

Packaged Items and Services

CMS is adopting to continue to conditionally package costs of selected newly identified ancillary services into payment for a primary service where CMS believes the packaged item or service is integral, ancillary, supportive, dependent, or otherwise adjunctive to the primary service.

For CY 2026, CMS is adopting to continue to unpackage, and pay separately at ASP+6%, the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting. CMS is unpackaging these drugs to address the decreased utilization of non-opioid pain management drugs and to encourage their use rather than prescription opioids. These drugs are only eligible if the drug or biological does not have transitional pass-through payment status and the drug must not already be separately payable in the OPPS or ASC payment system.

Table 131 lists the products that will have separate payment in the ASC setting under this policy for CY 2026.

Skin Substitutes

Since 2014, skin substitutes have been divided into a high-cost group and a low-cost group in terms of packaging under the OPPS. CMS assigns skin substitutes with a geometric MUC or a product's per day cost (PDC) that exceeds either the MUC threshold or the PDC threshold to the high-cost group.

Beginning Jan. 1, 2026, CMS is finalizing to separately pay for certain groups of skin substitute products as incident-to supplies under the MPFS in the non-facility setting or the OPPS setting. This includes unpackaging the skin substitute products from the payment for administration of the skin substitute product separate from the skin substitute product itself. CMS is adopting to remove skin substitutes from the list of packaged items and services and specify that CMS will continue to package payment for products that aid wound healing that are not skin substitute products.

In addition, CMS is finalizing to group skin substitutes that are not drugs or biologicals using three CMS payment categories based on FDA regulatory and adopting to create three new APCs:

- APC 6000 (PMA Skin Substitute Products)
- APC 6001 (510(k) Skin Substitute Products)
- APC 6002 (361 HCT/P Skin Substitute Products)

CMS is establishing an initial single payment rate of $127.14 (proposed at $125.38) for the three newly adopted APCs and will update the rates for skin substitute categories annually using the most recently available calendar quarter of ASP data. CMS is also finalizing to create three new unlisted C-codes and assigning them to existing codes to prevent delays in Medicare payments for new FDA approved or cleared skin substitute products as follows:

- Q4431 (Unlisted PMA skin substitute product) assigned to APC 6000 (PMA Skin Substitute Products)
- Q4432 (Unlisted 510(k) skin substitute product) assigned to APC 6001 (510(k) Skin Substitute Products)
- Q4433 (Unlisted 361 HCT/P skin substitute product) assigned to APC 6002 (361 HCT/P Skin Substitute Products)

Lastly, CMS is adopting to create status indicator, "S1" to indicate that the skin substitute product is paid separately from other procedure codes under the OPPS. The finalized "S1" indicator will be assigned to all skin substitute products assigned to APCs 6000, 6001, 6002. Table 114 details the adopted status indicator, the descriptor, and payment status.

Payment for Off-Campus Outpatient Departments – Drug Administration Services

In order to control what CMS deemed an unnecessary increase in OPPS service volume for a basic clinic visit representing a large share of the services provided at off–campus provider-based departments (PBDs), CMS expanded the Medicare Physician Fee Schedule (MPFS) payment methodology in CY 2019 to excepted off–campus PBDs for HCPCS code G0463. As of CY 2024, this policy has the following additional exemptions:

- Excepted off-campus PBDs belonging to rural SCHs;
- Application of the community mental health center (CMHC) per-diem rates for hospital partial hospitalization program (PHP) and intensive outpatient (IOP) services provided at an off-campus PBD, instead of the MPFS rate for that service; and
- Payment made for intensive cardiac rehabilitation (ICR) services.

For CY 2026, CMS is finalizing to extend this policy for drug administration services furnished in excepted off-campus PBDs. In line with CMS' policy to exempt rural SCHs from the clinic visit policy, CMS is adopting to exempt rural SCHs from the site-specific MPFS-equivalent payment for drug administration service when furnished at an off-campus PBD. Under this policy, rural SCHs will continue to bill services in APC family 569X with the "PO" modifier for CY 2026 and payment rates for these services will continue to be the full OPPS payment without the MPFS adjustment.

CMS also sought comments on whether it would be appropriate to address unnecessary increase in volume of covered OPD services by expanding the method to control unnecessary increases in volume to on-campus clinic visits. CMS will consider these comments in future rulemaking.

PHP and IOP Services

The PHP is an intensive outpatient psychiatric program that provides outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding CMHC. PHP providers are paid on a per-diem basis with payment rates calculated using CMHC-specific or hospital-specific data.

As required by the Consolidated Appropriations Act (CAA) of 2023, CMS adopted payment and program requirements for intensive outpatient program services beginning CY 2024. Intensive outpatient services are furnished under a distinct and organized outpatient program of psychiatric services for individuals who have an acute mental illness, called an IOP. IOP services are less intensive than PHP services and can be furnished by a hospital to its outpatients, a CMHC, a federally qualified health center, or a rural health clinic.

The table below compares the final CYs 2025 and 2026 PHP and IOP payment rates as found in Addendum A:

	Final Payment Rate 2025	Final Payment Rate 2026	% Change
APC 5851: Intensive Outpatient (3 services) for CMHCs	$111.24	$127.74	+14.83%
APC 5852: Intensive Outpatient (4+ services) for CMHCs	$168.32	$167.38	-0.56%
APC 5853: Partial Hospitalization (3 services) for CMHCs	$111.24	$127.74	+14.83%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	$168.32	$167.38	-0.56%
APC 5861: Intensive Outpatient (3 services) for Hospital-based IOPs	$269.19	$319.38	+18.64%
APC 5862: Intensive Outpatient (4+ services) for Hospital-based IOPs	$408.55	$418.45	+2.42%
APC 5863: Partial Hospitalization (3 services) for Hospital-based PHPs	$269.19	$319.38	+18.64%
APC 5864: Partial Hospitalization (4+ services) for Hospital-based PHPs	$408.55	$418.45	+2.42%

For CY 2026, CMS is finalizing for CMHC PHP and IOP APCs a revised methodology to calculate the CY 2026 geometric mean per diem costs based on 40% of the finalized hospital-based PHP costs for CY 2026 and subsequent years. Using the current methodology would result in inverted costs for CMHCs with

higher geometric mean costs for 3-service than for 4-service. CMS believes the adopted methodology would stabilize CMHC payment rates by setting them relative to hospital-based rates, while avoiding cost inversion in future years. Table 118 lists the PHP and IOP APC geometric mean per diem costs based on the adopted methodology.

CMS will continue to make outlier payments to CMHCs for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year. As done in prior years, CMS is finalizing to apply an 8% outlier payment cap to the CMHC's total per diem payments. CMS will also continue to include both PHP and IOP in the calculation of the CMHC outlier percentage.

Inpatient – Only List

The IPO list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. For CY 2026 and subsequent years CMS is finalizing to eliminate the IPO list through a three-year transition, beginning in CY 2026 and completing the elimination by Jan. 1, 2029. For CY 2026, CMS will remove 285 services (mostly musculoskeletal procedures) from the IPO list which can be found in Table 119.

In addition, CMS will exempt procedures that have been removed from the IPO list from certain medical review activities to assess compliance with the 2-midnight rule. The exemption will continue for all services or procedures removed from the IPO list until the Secretary determines that the exemption is no longer appropriate for each specific service or procedure because it is more commonly performed in the outpatient setting.

Lastly, CMS finalized modifications to the IPO polices. CMS had proposed to continue the exemption from site of service denials and medical review contract referrals for procedures removed from the IPO list consistent with the CY 2021 OPPS policy. The proposal also included technical revisions to clarify regulatory texts for procedures removed on or after Jan. 1, 2021. After considering public comments CMS modified the proposal by both reaffirming and refining this policy:

- CMS finalized the indefinite continuation of the exemption from site of service claim denials, RAC patient status reviews and related medical review activities for all procedures removed from the IPO list, while also revising and removing outdated regulatory language.
- CMS clarified that all procedures removed from the IPO list on or after Jan. 1, 2021, remain exempt from certain medical review determinations ensuring consistent protection for providers until CMS determines that the procedure is routinely performed in outpatient setting.

CMS sought comments on whether three years is an appropriate time frame for the transition, and whether other services are ideal candidates for removal from the IPO list in the near term. CMS also sought comments on whether CMS should restructure or create new APCs or C-APCs to allow for efficient OPPS payment for services that are removed from the IPO list.

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

The Bipartisan Budget Act of 2018 required that services provided in a CR, ICR, or FR program be provided under the supervision of a physician's assistant (PA), nurse practitioner (NP), or clinical nurse specialists (CNS) beginning Jan. 1, 2024, rather than the current requirement that only physicians can supervise these services as part of the stated programs. In the CY 2024 MPFS final rule, CMS adopted revisions to the regulations in order to match the new requirements.

In the April 6, 2020 "Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency" interim final rule with comment period, CMS adopted that during a PHE, for the purposes of direct supervision, a physician can be present virtually through audio/video real-time communications technology for FR, CR, and ICR services when the use of technology reduces exposure risks for the patient or the provider. The CAA of 2023 extends this policy through the end of CY 2024. In order to maintain similar policies for OPPS as MPFS, CMS adopted the inclusion of FR, CR, and ICR with supervision from an NP, PA, or CNS under this policy.

In the CY 2025 MPFS final rule, CMS finalized an extension of the availability of virtual direct supervision of therapeutic and diagnostic services under the MPFS. In the CY 2026 MPFS final rule, CMS adopted to revise the definition of direct supervision to make permanent the availability of virtual direct supervision of therapeutic and diagnostic services under the PFD, except for services that have a global surgery indicator of 010 or 090. To maintain alignment between the MPFS and OPPS, CMS is also adopting a revision 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 surgery indicator of 010 or 090.

Measure Removals from the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

Beginning with the CY 2025 reporting period/CY 2027 payment determination, CMS is finalizing to remove the following measures from the Hospital OQR and ASCQR programs originally adopted in the CY 2025 OPPS final rule:

- Screening for Social Drivers of Health (SDOH)
- Screen Positive Rate for SDOH measures

CMS is also finalizing the removal of the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR, and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR program beginning with the CY 2025 reporting period/CY 2027 performance period.

For the Hospital OQR and ASCQR programs CMS is finalizing to remove the COVID-19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 payment determination.

Extraordinary Circumstance Exception (ECE) Policy

In the Hospital OQR and ASCQR programs CMS is finalizing to update and codify the ECE policy to include extensions of time as a form of relief and to further clarify the policy, as well as to align the Hospital IQR program with the quality reporting programs. Specifically, these adoptions note:

- CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital or ASC (for example a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital or ASC to comply with one or more applicable reporting requirements with respect to a calendar year.
- A hospital or ASC, respectively, may request an ECE within 60 calendar days [down from the current 90 days] of the date that the extraordinary circumstance occurred.
- CMS notifies the ASC of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the ASC, the written decision specifies whether the ASC is exempted from one or more reporting requirements or whether CMS has granted the ASC an extension of time to comply with one or more reporting requirements.

- CMS may grant an ECE to one or more hospitals or ASCs that have not requested an ECE, if CMS determines that: a systemic problem with CMS data collection system directly impacted the ability of the hospital or ASC to comply with a quality data reporting requirement; or that an extraordinary circumstance has affected an entire region or locale. As is the case under our current policy, any ECE granted will specify whether the affected hospitals or ASCs are exempted from one or more reporting requirements or whether CMS has granted the hospital or ASC an extension of time to comply with one or more reporting requirements.

Updates to the OQR Program

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 PPT reduction to the OPPS market basket update for the applicable year.

In addition to the changes listed in the section above, CMS is adopting the Emergency Care Access & Timeliness electronic clinical quality measures (eCQM) beginning with voluntary reporting for the CY 2027 reporting period, and mandatory reporting beginning with the CY 2028 reporting period/ CY 2030 payment determination.

CMS is removing two measures beginning with the CY 2028 reporting period/CY 2030 payment determination:

- Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients)
- Left without Being Seen

Additionally, CMS is modifying the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level-Outpatient) measure from mandatory reporting to voluntary reporting in the CY 2027 reporting period. This modification will allow hospital outpatient departments additional time to integrate, test and gain experience with implementing the eCQM and allow CMS additional time to monitor implementation progress, data collection burden, and response rates. CMS intends to propose mandatory reporting of data in the CY 2027 OPPS/ASC proposed rule. Table 138 lists the previously finalized and newly finalized Hospital OQR program measure set for the CY 2026 to CY 2031 payment determinations.

For the Emergency Care Access & Timeliness eCQM, CMS is finalizing the requirement for hospitals to report all four calendar quarters of data for Emergency Care Access & Timeliness eCQM and requiring data submission by May 15 in the year prior to the affected payment determination.

Modification to the Overall Hospital Quality Star Rating

In the CY 2025 OPPS final rule CMS included an RFI discussing potential methodologic modifications to the Safety of Care measure group within the Overall Hospital Quality Star Rating. After considering public input, CMS is adopting a two-stage modification to the Overall Hospital Quality Star Rating methodology:

- Stage 1: implement a 4-star cap for hospitals in the lowest-performing quartile of the Safety of Care measure group for the 2026 Overall Hospital Quality Star Rating
- Stage 2: implement a 1-star reduction, to a minimum 1-star rating for hospitals in the lowest-performing quartile of the Safety of Care measure group for the 2027 Overall Hospital Quality Star Rating and thereafter.

Under Stage 1 the cap will be applied to hospitals that are initially assigned five stars in step eight of the methodology but have a Safety of Care score in the lowest-performing quartile to four stars. Stage 2 will

apply a blanket one-star reduction to hospitals initially assigned a two-, three-, four-, or five-star rating in step eight of the methodology, but have a Safety of Care score in the lowest performing quartile. With a minimum possible Overall Hospital Star Rating of one star, hospitals already receiving one star will not face further star reduction and will be exempt from this methodology update.

Hospital Price Transparency (HPT)

In alignment with EO 14221, ‘‘Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare”, CMS is adopting modifications to the HPT regulations to enhance clarity and standardization in hospital pricing disclosures. Among the amendments include revisions to add definitions for the “10th percentile allowed amount”, “median allowed amount”, and “90th percentile allowed amount” to allow hospitals to more accurately reflect the distribution of actual amounts that a hospital has received for an item or service. In tandem, CMS is also adopting revisions to remove the requirement for hospitals to disclose the estimated allowed amount, and instead require hospitals, beginning CY 2026, to disclose the 10th percentile, median, and 90th percentile allowed amounts, and count of allowed amounts in Machine-Readable Files (MRFs) when payer-specific negotiated charges are based on percentages or algorithms.

CMS is also finalizing to require hospitals to use electronic data interchange 835 electronic remittance advice transaction data or an alternative equivalent source of remittance data to calculate and encode the allowed amounts and require that hospitals comply with specific instructions regarding the methodology, including a lookback period of no less than 12 months and no longer than 15 months prior to posting the MRF, that must be used to calculate these amounts. CMS will be delaying the enforcement of these finalized revisions until April 1, 2026. They believe that this 3-month delay will provide hospitals with sufficient time to update their systems, and review, validate and post their files.

Beginning CY 2026, CMS is finalizing to require hospitals to attest in the MRF that the hospital has included all applicable standard charge information in accordance with the requirements and information encoded is true, accurate, and complete as of the date in the file. Hospitals will also have to 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.

In addition, CMS is finalizing that hospitals encode the name of the hospital chief executive officer, president, or senior official designated to oversee the encoding of true, accurate, and complete data in the MRF. To advance the comparability of HPT data with other healthcare data, CMS is finalizing to require hospitals to encode their National Provider Identifiers in the MRFs. To encourage faster resolution and payment of civil monetary penalties (CMPs), CMS is finalizing to reduce the amount of a CMP by 35% when a hospital agrees with CMS’ determination of a hospital’s noncompliance and waives its right to an administrative law judge hearing.

In cases where the hospitals report the payer-specific negotiated share as a percentage or algorithm on the MRF, CMS is adopting that hospitals will instead use the “median allowed amount” to calculate the negotiated charges to report on the Medicare cost report.

Market-Based Medicare Severity-Diagnosis Related Groups (MS-DRG) Relative Weights

CMS is finalizing a new market-based methodology for estimating the MS-DRG relative weights, beginning in FY 2029. The adopted market-based methodology will be the same methodology that was

adopted in the FFY 2021 IPPS final rule where relative weights are calculated using the median payer-specific negotiated charge for Medicare Advantage Organizations (MAOs) for each MS-DRG. CMS is also finalizing to require hospitals to report the median payer-specific negotiated charge with all of its MAOs, by MS-DRG on the Medicare cost report beginning in CY 2026.

Graduate Medical Education

To align efforts with EO 14279, "Reforming Accreditation to Strengthen Higher Education" CMS is finalizing that accrediting organizations may not use accreditation standards that require encourage or rely on criteria based on protected classes (race, color, national origin, sex, age, disability, religion) or proxies for those characteristics when making decisions about employment participation or allocation of resources.

In this final rule, CMS is providing public notification of the closure of a teaching hospital for the purpose of the established application process for the resident slots attributed to this hospital.

CCN	Provider Name	City/State	CBSA	Terminating Date	IME Cap (includes all adjustments)	Direct GME Cap (includes all adjustments)
230013	Pontiac General Hospital	Pontiac, MI	47664	November 24,2024	33.753	30.444

Notice of Intent to Conduct Medicare OPPS Drugs Acquisition Cost Survey

As required by section 1833(t)(14)(A)(iii) of the Social Security Act, CMS will be conducting a survey of acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS, including specific covered outpatient drugs (SCODs), and drugs and biologicals CMS historically treats as SCODs. The required survey will open from the end of CY 2025 to early CY 2026, and CMS intends to use survey results to inform policy making beginning with the CY 2027 OPPS proposed rule.

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