National Rural Health Association

Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment System Final Rule

On November 21, 2025, the Centers for Medicare and Medicaid Services (CMS) released its CY 2026 Outpatient Prospective Payment System (OPPS) final rule.

For more information, see the summary below or find CMS' fact sheet here. If you have any questions, please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel (amckinley@ruralhealth.us).

Key provisions:

Payment policies. CMS is finalizing a **2.6% payment update for OPPS hospitals**. This is higher than the proposed 2.4% increase. NRHA is pleased to see that CMS finalized a higher payment update than originally proposed. Rural hospitals will see closer to a 2.3% update.

CMS finalized proposed updated payment rates and continued alignment of hospital-based Intensive Outpatient Program (IOP) services. Hospitals and rural health clinics (RHCs) will be paid $340.90 for 3-service days and $424.60 for four or more services per day. This represents a slight increase from the CY 25 update.

CMS is finalizing its proposal to continue to separately pay an add-on to the all-inclusive rate (AIR) to Indian Health Service and tribal hospitals for all high-cost drugs administered in hospital outpatient departments whose per day cost exceeds two times the Medicare Outpatient per Visit Rate for the lower 48 states' AIR ($1,436 in CY 2026).

340B remedy recoupment. In 2022, the Supreme Court struck down CMS' payment policy for 340B drug payments. At the time, CMS had a policy in place to pay hospitals for 340B-acquired drugs at the average sales price (ASP) -22.5%. Savings from this policy were redistributed back to all hospitals in the form of increased reimbursement for non-drug items and services. In response to the Court's decision, CMS provided lump sum payments to make 340B hospitals whole and finalized a policy to recoup the payment increases to hospitals in place during CYs 2018 – 2022 through instituting a 0.5% payment reduction over 16 years. The payment reduction was set to begin in CY 2026.

In the proposed CY 2026 OPPS rule, CMS proposed accelerating this recoupment to 2% per year for six years. In the final rule, **CMS retains the previously finalized 0.5% reduction for CY 2026 while stating it may increase offsets through future rulemaking.** NRHA is pleased to see that CMS did not finalize the accelerated recoupment as it would have disproportionately harmed rural PPS hospitals.

Site neutral payment for drug administration. CMS finalized its proposal to apply site neutral payment rates for off-campus drug administration services. This means that the Medicare Physician Fee Schedule equivalent rates will be paid for drug administration services in off-campus provider-based departments. This change will overall reduce OPPS payment for these services by approximately 60% beginning January 1, 2026. **This update applies to all off-campus provider-based departments except rural Sole Community Hospitals (SCHs).**

Drug acquisition cost survey. Beginning January 1 through March 31, 2026, CMS will conduct its first survey of hospital acquisition costs for OPPS drugs as directed by statute. Hospitals must report

acquisition cost data for drugs purchased between July 1, 2023, and June 30, 2025. Critical access hospitals are not included because they are not paid under OPPS.

Although CMS cannot impose penalties for non-response, it may consider using proxy values for non-responding hospitals, like the lowest acquisition cost reported by hospitals. CMS will use survey results to inform drug pricing as soon as the CY 2027 rulemaking cycle is complete. Please note that the Supreme Court struck down CMS' ASP -22.5% payment policy for 340B-acquired drugs (discussed above) because CMS did not perform this survey as required by statute before implementing a new payment rate. This means that once CMS performs this acquisition cost survey, it may implement a similar payment cut for 340B-acquired drugs.

You can find a draft survey tool here.

Hospital price transparency regulations. Consistent with Executive Order 14221 issued earlier this year directing that HHS require disclosure of actual prices and ensure pricing information is easily comparable across hospitals, **CMS finalized several major updates effective January 1, 2026, with enforcement beginning April 1, 2026.** First, CMS is finalizing the proposed definitions of "median allowed amount," "10th percentile allowed amount," and "90th percentile allowed amount" with modification to reflect a lookback period of no less than 12 months and no longer than 15 months prior to posting the machine readable file (MRF). Hospitals will now be required to make public the actual dollar amounts in their MRF and must replace estimated allowed amounts with the median allowed amount, 10th percentile allowed amount, and 90th percentile allowed amount.

CMS also finalized the requirement to submit formal attestation stating that the MRF is accurate, complete and approved by the hospital CEO or designated senior official.

Find CMS' fact sheet on hospital price transparency updates here.

Inpatient-only (IPO) list. CMS finalized its proposal to eliminate the IPO list over a 3-year transition beginning in CY 2026, with the list fully eliminated by January 1, 2029. For CY 2026, CMS removes 285 mostly musculoskeletal services from the IPO list as the first step of this transition. CMS emphasizes that removal from the IPO list does not require that procedures be performed only on an outpatient basis. Physicians may still admit patients as inpatients consistent with the 2-midnight rule and the 3-day inpatient stay requirement for SNF coverage remains unchanged.

Virtual direct supervision. CMS finalized permanent virtual direct supervision of cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation services and most diagnostic services using real time, two-way audio/video communications technology (excluding audio-only).

Hospital Quality Star Rating Modification. CMS finalized updates to the methodology used to calculate the Overall Hospital Quality Star Rating to elevate the importance of the safety of care measure group. CMS noted that under the current methodology, some hospitals received high star ratings despite ranking in the lowest quartile on safety of care. To address this, the agency is implementing a two-stage methodology update.

- Stage 1 – Transitional Update for the 2026 Star Ratings:
    - Beginning with 2025, hospitals that have at least three safety of care measure scores and perform in the lowest quartile of the safety of care measure group will be capped at a

maximum rating of four stars, ensuring hospitals with poorest safety outcomes cannot achieve a five-star rating during the first year of the update.

- Stage 2 – Full Implementation for 2027 and Subsequent Years:
    - Beginning with the 2027 Star Ratings and for future years, CMS will reduce the rating by one star for any hospital that has at least three safety of care measure scores and ranks in the lowest quartile of the measure group. Hospitals subject to the reduction will receive no lower than a 1-star rating.

Quality reporting programs. CMS is finalizing changes affecting both the Hospital Outpatient Quality Reporting Program (OQR) and Rural Emergency Hospital Quality Reporting Program (REHQR).

- For both the ORQ and REQHR programs, CMS is removing:
    - COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) effective CY 2024 reporting and CY 2026 payment determination.
    - Hospital Commitment to Health Equity (HCHE) effective CY 2025 reporting and CY 2027 payment or program determination.
    - Screening for Social Drivers of Health (SDOH) and Screen Positive Rate for SDOH effective CY 2025 reporting period.
- For the REHQR program CMS finalized the addition of:
    - The Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination as an optional measure. This would be an alternative to reporting the Median Time from ED Arrival to ED Departure for Discharged Patients measure.
- Other cross-program policies:
    - CMS received comments supporting future wellbeing and nutrition measure concepts and will continue exploring them for later rulemaking.
    - CMS finalized its proposal to update and codify the Extraordinary Circumstance Exception (ECE) policy, clarifying CMS' discretion to grant extensions for OQR and REHQR.

Market-based MS-DRG methodology and MA data collection. CMS finalized a requirement that hospitals report the median payer-specific negotiated charge by MS-DRG for all Medicare Advantage organizations (MAO) on the Medicare cost report, effective for cost reporting periods ending on or after January 1, 2026. CMS will use these data to implement a new MS-DRG relative weight methodology beginning in FY 2029, under which MS-DRG weights will be based on the weighted median MAO negotiated charges rather than cost-based estimates.