National Rural Health Association

Calendar Year (CY) 2026 Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

Last week, the Centers for Medicare and Medicaid Services (CMS) published its CY 2026 Outpatient Prospective Payment System (OPPS) **proposed rule.** For more information, find CMS' fact sheet **here** or a summary below.

Comments are due on **September 15, 2025,** via regulations.gov. If you have any questions or comments that you would like addressed in NRHA's response, please contact Alexa McKinley Abel (amckinley@ruralhealth.us) by August 27. Stay tuned for a comment template to help you submit your own response.

Key proposals include:

Payment. CMS proposes a **2.4% increase in payment rates for hospitals** compared to CY 2025. The update is based on a projected 3.2% hospital market basket increase, reduced by a 0.8 percentage point productivity adjustment. Total payments for hospital outpatient services are projected to reach $100 billion. Hospitals that fail to meet outpatient quality reporting requirements will receive a 2% reduction.

However, after considering all proposals in the proposed rule, **rural hospitals will see an increase of 2% over CY 2025.** As explained below, rural hospitals subject to the 340B remedy recoupment will see another 2% reduction to that payment rate.

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 also 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 is set to begin in CY 2026.

However, CMS now proposes to speed up this recoupment by **quadrupling the reduction to OPPS payments from 0.5% to 2%, shortening the recoupment period from 16 years to 6 years**. This accelerated recoupment is intended to offset budget-neutral payment increases from past 340B drug payment cuts between CY 2018 and 2022, even though those increases were distributed across all OPPS hospitals, not just 340B participants. This policy applies broadly to non-drug items and services paid under OPPS, excluding hospitals that enrolled in Medicare after January 1, 2018.

While intended to recover $7.8 billion in excess payments, **the accelerated 2% reduction will apply to both 340B and non-340B hospitals.** This means that most rural hospitals will not see a payment increase in CY 2026.

Acquisition Cost Survey for Drugs. **CMS announced its intent to conduct a hospital acquisition cost survey for separately payable outpatient drugs in early CY 2026.** The survey results will inform drug pricing beginning in the CY 2027 OPPS rule. As a reminder, 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.

Site Neutral Payments. CMS is proposing to **expand site neutral payment policies by applying Medicare Physician Fee Schedule (MPFS) equivalent rates to drug administration services provided in excepted off-campus provider-based departments (PBDs)**. This proposal represents a roughly 65% reduction in reimbursement for these services from current OPPS payment rates and is projected to reduce OPPS spending by $280 million, including $70 million in savings for Medicare beneficiaries in CY 2026. The agency justifies the change as a way to control unnecessary increases in service volume and is also soliciting comment on expanding site neutrality to on-campus clinic visits and imaging services in future rulemaking. **Sole Community Hospitals (SCH) are exempt from this policy.** CMS is also seeking feedback on whether this policy should be expanded to on-campus clinic visits.

Hospital Price Transparency (HPT). CMS proposes to require that hospitals disclose the tenth, median, and ninetieth percentile allowed amounts in machine-readable files (MRFs) for items and services.

CMS also proposes revisions to current attestation of data accuracy by hospital executives. Beginning January 1, 2026, hospitals would have to attest that their MRF includes all applicable standard charge information; that all information is true, accurate, and complete; and that all payer-specific negotiated charges are expressed as dollar amounts. Hospitals would also have to encode the name of the hospital CEO, president, or senior official that oversees the encoding of true, accurate, and complete data.

CMS proposes a 35% penalty reduction for hospitals that accept CMS noncompliance determinations without contest.

Hospital Outpatient Quality Reporting (OQR) Program. CMS outlines several changes to the OQR Program intended to streamline reporting and improve the relevance of quality measures. First, CMS proposes the adoption of a new electronic clinical quality measure (eCQM), Emergency Care Access & Timeliness, which would be introduced with voluntary reporting beginning in the CY 2027 reporting period and transition to mandatory reporting beginning in CY 2028 for the CY 2030 payment determination. This eCQM is intended to replace two existing emergency department-related measures.

As part of a broader effort to reduce reporting burden and phase out measures that are no longer aligned with CMS priorities, the agency proposes to remove several existing measures from the program. These include:

- COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period/CY 2026 payment determination,
- Hospital Commitment to Health Equity (HCHE) measure beginning with the CY 2025 reporting period/CY 2027 payment determination,
- Two social drivers of health (SDOH) measures: Screening for SDOH and Screen Positive Rate for SDOH, both beginning with the CY 2025 reporting period.

CMS proposes the conditional removal of two longstanding emergency department measures, the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients and the Left Without Being Seen measure beginning with the CY 2028 reporting period/CY 2030

payment determination. This removal is contingent upon final adoption of the Emergency Care Access & Timeliness eCQM, which is intended to provide a more comprehensive and electronically generated alternative to these measures.

CMS also proposes extending the voluntary reporting period for the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in adults eCQM, beginning with the CY 2027 reporting period.

Finally, CMS proposes an update to the OQR Program's Extraordinary Circumstances Exception (ECE) Policy. The proposed revision would explicitly allow for "extensions" in addition to existing "exceptions," thereby giving hospitals more flexibility in requesting relief from reporting obligations due to unforeseen or uncontrollable events.

Rural Emergency Hospital (REH) Quality Reporting (REHQR) Program. CMS proposes a new optional quality measure for REHs: Emergency Care Access & Timeliness eCQM. Beginning with the CY 2027 reporting period and applying to the CY 2029 program determination, REHs may choose to report this eCQM as an alternative to the current measure, Median Time from ED Arrival to ED Departure for Discharged ED Patients. CMS is also proposing related data submission and technical reporting requirements for REHs that opt to report the new eCQM.

CMS proposes revising the REHQR Program's ECE policy. The update would explicitly allow for both "exceptions" and "extensions," providing REHs with more flexibility in responding to unforeseen disruptions or barriers that prevent timely or complete data submission. This clarification aligns with changes proposed across all outpatient quality reporting programs.

Inpatient only (IPO) list. CMS proposes to eliminate the IPO list over a three-year transition period, beginning with the removal of 285 predominantly musculoskeletal procedures in CY 2026. These procedures would be paid under OPPS when clinically appropriate, giving physicians more flexibility in choosing the site of care. CMS will continue to exempt procedures recently removed from the IPO list from certain two-midnight rule medical review activities until it determines that these services are commonly performed in outpatient settings.

Software as a Service (SaaS). CMS is soliciting comments on future payment policy development for software as a service technology used in clinical decision-making. The agency is interested in how SaaS could be reimbursed under OPPS and whether value-based or bundled methodologies may be appropriate.

Market-Based MS-DRG Relative Weight Data Collection and Methodology. CMS is proposing to collect from hospitals the median payer-specific charges that they have negotiated with Medicare Advantage (MA) organizations and disclosed under CMS' HPT rules and then use these data to help determine relative Medicare payment rates for inpatient hospital services. CMS is also seeking comment on how market-based approaches such as this one could be utilized to improve additional Medicare FFS payment systems.

Intensive Outpatient Program (IOP). The proposed rule updates Medicare payment rates for IOP services furnished in hospital outpatient departments and community mental health centers (CMHCs). The IOP is an outpatient program of psychiatric services provided for individuals who have an acute mental illness or substance use disorder, consisting of a specified group of behavioral health services paid on a per diem basis for a minimum of 9 hours of IOP services per week under the OPPS, or other applicable payment system, when furnished in hospital outpatient departments, CMHCs,

Federally Qualified Health Centers (FQHCs), and rural health clinics (RHCs). IOP services may also be furnished in Opioid Treatment Programs (OTPs) for opioid use disorder (OUD) treatment.

For CY 2026, CMS proposes to maintain the existing IOP payment methodology for hospital-based providers. Hospital-based IOP rates would continue to be calculated using OPPS data from CY 2024 claims and cost reports. However, CMS proposes a new methodology for community mental health centers (CMHCs), setting their IOP payment rates at 40% of the hospital-based rates.

CY 2026 rates for IOP providers are as follows:

- Hospital-based:
  - 3 services per day: $340.90
  - 4+ services per day: $424.60
- CMHCs:
  - 3 services per day: $191.83
  - 4+ services per day: $110.39

Partial hospitalization program (PHP). CMS proposes the same payment methodology revision for CMHCs as in the IOP.

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  - 3 services per day: $340.90
  - 4+ services per day: $424.60
- CMHCs:
  - 3 services per day: $191.83
  - 4+ services per day: $110.39

Request for Information for the Hospital Outpatient, REH and ASC Quality Reporting Programs. In addition to the proposed changes to the OQR, REHQR, and ASCQR Programs described, CMS is seeking public input on future quality measures related to well-being and nutrition. The agency seeks feedback on tools and frameworks that assess emotional well-being, life satisfaction, and healthy behaviors.

Overall Hospital Quality Star Rating Proposed Modification. To strengthen the role of patient safety, CMS proposes a two-stage update to the Overall Hospital Quality Star Rating methodology. Beginning in 2026, hospitals in the lowest quartile of Safety of Care performance would be capped at four stars. Starting in 2027, those hospitals would face a one-star deduction. These changes are intended to ensure that top-rated hospitals also meet high patient safety standards.