CMS Releases 2026 Payment Rules

The Centers for Medicare & Medicaid Services ("CMS") recently released its Federal Fiscal Year ("FFY") inpatient prospective payments system ("IPPS") final rule[1] as well as the Calendar Year ("CY") 2026 proposed rules for the outpatient prospective payment system ("OPPS")[2] and physician fee schedule ("PFS")[3]. The following summarizes key policies in these rules.

I. IPPS

On July 31, 2025, CMS published its annual final rule for the federal fiscal year ("FFY") 2026 IPPS and long-term care hospital ("LTCH") payment system. Below is a summary of the final rule.

A. Medicare DSH

In the proposed FFY 2026 IPPS rule, CMS did not propose any changes to traditional disproportionate share hospital ("DSH") payments but did make proposals relating to updates in the factors used for determining DSH uncompensated care payments. In the final rule, CMS finalized that for FFY 2026, CMS will increase DSH uncompensated care payments to hospitals by approximately $2 billion. Consistent with policy applied since FFY 2014, CMS will calculate Factor 1 as the difference between the most recently available estimates of the aggregate amount of Medicare DSH payments that would be made for FFY 2026 in the absence of Section 1886(r) of the Social Security Act (the "Act") and the amount of empirically justified Medicare DSH payments made for the fiscal year.[4] Under the final rule, Factor 1 for FFY 2026 is $12.413 billion—an increase from the proposed $11.761 billion.[5] CMS will continue to calculate Factor 2 by applying the weighted average approach to estimate the rate of uninsurance that hospitals will experience during the fiscal year. Under the final rule, Factor 2 for FFY 2026 is 62.14%, and the final FFY 2026 uncompensated care amount is $7,713,127,500.[6] To calculate Factor 3, CMS will continue using the three most recent years (FFY 2020, FFY 2021, and FFY 2022) of audited data on uncompensated care costs from Worksheet S–10 of the cost reports.[7] Additionally, CMS will continue using the same methodological approach for determining Factor

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[1] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (CMS-1833-F; CMS-1808-F) (July 31, 2025); 90 Fed. Reg. 36536 (August 4, 2025).
[2] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency (CMS-1834-P) (July 17, 2025); 90 Fed. Reg. 33476 (July 17, 2025).
[3] Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P) (July 16, 2025); 90 Fed. Reg. 32352 (July 16, 2025).
[4] 90 Fed. Reg. 36883.
[5] 90 Fed. Reg. 36886.
[6] 90 Fed. Reg. 36889.
[7] 90 Fed. Reg. 36892.

3, the hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that receive DHS payments, that it used for FFY 2025.[8] Specifically, Factor 3 is the quotient of the amount of uncompensated care for a hospital for a period selected by the HHS Secretary and the aggregate amount of uncompensated care for all subsection (d) hospitals that receive payment under Section 1886(r) of the Act for such period.[9] If a cost report covers a period that is more or less than 12 months, CMS will annualize the UCC from Worksheet S-10 Part I and "if applicable, use the statewide CCR [cost-to-charge ratio] (urban or rural) to calculate uncompensated care costs."[10]

B. Changes in IPPS Payment Rates, LTCH PPS Payment Rates and Other Proposed Changes to the LTCH PPS for FFY 2026

Overall, CMS finalized an increase of 2.6% to the IPPS payment rates for FFY 2026, an increase from the proposed rule's 2.4%.[11] The FFY 2026 increase is the result of a 3.3% increase to the market basket percentage estimate, offset by a 0.7% decrease due to the productivity adjustment.[12] CMS also finalized a 2.7% increase in the national standardized amount for long-term care hospitals for the next federal fiscal year.[13] CMS estimates these changes will result in an increase of approximately $5.0 billion in FFY 2026 payments to acute care hospitals and approximately $83 million in FFY 2026 payments to LTCHs.[14]

C. Changes to Low-Volume Hospital Definition and Payment Adjustment

Beginning with discharges occurring on or after October 1, 2025, CMS will revert the definitions of "low-volume hospital" and the corresponding payment adjustment methodology back to those adopted under the statutory requirements in effect between FFY 2005 and FFY 2010.[15] Such reversion to the original text of § 1886(d)(12) of the Act, requires the Secretary to develop an empirically justifiable adjustment, that is, an applicable percentage increase for low-volume hospitals based on an empirical relationship between the standardized cost-per-case for such hospital and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) associated with the number of such charges.[16] In the final rule, CMS finalized an empirically justifiable payment adjustment of 25%.[17] Additionally, beginning in FFY 2026, a "low-volume hospital" must be more than 25 road miles from another subsection (d) hospital and have fewer than 200 discharges during the fiscal year.[18] Consistent with previous years, CMS clarified that hospitals must submit written requests for low-volume hospital status to their Medicare contractor by September 1 immediately preceding the start of

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[8] 90 Fed. Reg. 36547.
[9] 90 Fed. Reg. 36890.
[10] 90 Fed. Reg. 36893.
[11] 90 Fed. Reg. 36902.
[12] 90 Fed. Reg. 36904.
[13] 90 Fed. Reg. 37237.
[14] 90 Fed. Reg. 37253.
[15] 90 Fed. Reg. 36909.
[16] *Id*.
[17] 90 Fed. Reg. 36910.
[18] *Id*.

the FFY for which the hospital is applying for low-volume status and include sufficient documentation to establish that they meet the applicable mileage and discharge criteria.[19]

D. Changes in the Medicare-Dependent, Small Rural Hospital Program

Under current law, beginning October 1, 2025, all hospitals that previously qualified for Medicare-dependent hospital ("MDH") status will no longer have MDH status as the MDH program will end, unless Congress passes legislation to extend the program.[20] Absent Congressional action, all hospitals will receive the same Federal rate, not the higher of the federal rate or a blended rate based partly on the MDH's specific rate. CMS finalized updates to the rules for the MDH program at § 412.108(a)(1) and (c)(2)(iii) and the general payment rules at § 412.90(j) to match the end date of September 30, 2025 for the MDH program.[21]

E. GME/IME - Calculating Full-time Equivalent Counts and Caps for Cost Reporting Periods Other than 12 Months

CMS did not propose any changes to its proration methodology for cost reporting periods other than 12 months, but rather clarified the current, pre-existing methodology for determining the total Direct Graduate Medical Education ("GME") and Indirect Graduate Medical Education ("IME") counts for a non-12-month cost reporting period.[22]

F. Changes Regarding the Calculation of Net Cost of Nursing and Allied Health Education

CMS did not finalize proposed amendments to its regulations concerning calculation of the net cost of nursing and allied health education ("NAHE"). Specifically, CMS had proposed amending 42 CFR § 413.85(d)(2)(i) to state that the net cost of approved educational activities is determined as follows: (1) determine allowable direct costs incurred by the provider for trainee stipends and compensation of teachers employed by the provider; (2) subtract from allowable direct costs the revenues the provider receives from students or on behalf of students enrolled in the program, such as, but not limited to, tuition, student fees, or textbooks purchased for resale; and (3) add indirect costs of the activities as determined under the Medicare cost-finding principles in 42 CFR § 413.24, but limited to indirect costs that the provider itself incurs as a consequence of operating the approved educational activities.[23] However, after receiving many comments in opposition to the proposal, CMS decided not to final changes to existing policy in this final rule, but expects to revisit the treatment of NAHE costs in future rulemaking.

G. Hospital Readmissions Reduction Program Updates and Changes

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[19] 90 Fed. Reg. 36912.
[20] 90 Fed. Reg. 36914.
[21] *Id*.
[22] 90 Fed. Reg. 36916.
[23] 90 Fed. Reg. 36920.

CMS finalized significant updates to the Hospital Readmissions Reduction Program ("HRRP").[24] These updates include incorporating Medicare Advantage ("MA") data into the six readmission measures, alongside existing Medicare fee-for-service ("FFS") data.[25] Additionally, the "applicable period" for measuring performance will be shortened from three years to two years, with this change codified into the program's regulations.[26] The calculation of aggregate payments for excess readmissions will also be modified to include MA data, specifically by using the Medicare Provider Analysis and Review ("MedPAR") file or the most up-to-date payment sources for both Medicare FFS and MA beneficiaries who meet the criteria for each condition or procedure.[27] Furthermore, CMS updated its Extraordinary Circumstance Exception ("ECE") policy, granting the agency the discretion to provide extensions or exemptions in response to ECE requests from hospitals affected by events like natural disasters, further clarifying the process and notification requirements.[28] The final rule also includes the removal of COVID-19 exclusions and risk-adjustment covariates from the six readmission measures, while integrating MA beneficiaries into each measure's cohort and updating the risk adjustment model to use individual ICD-10 codes.[29] These changes are set to begin with the FFY 2027 program year. The updates are made under section 1886(q) of the Act, as amended by Section 15002 of the 21st Century Cures Act, 2016 (Public Law 114-255).

H. Hospital Value-Based Purchasing Program

CMS finalized updates to the Hospital-Level Risk-Standardized Complication Rate ("RSCR") following electing primary total hip arthroplasty ("THA") and/or total knee arthroplasty ("TKA").[30] In addition, CMS finalized technical updates with respect to (1) the five condition- and procedure-specific mortality measures (MORT-30-AMI, MORT-30-HF, MORT-30-COPD, MORT-30-CABG, MORT-30-PN) and the COMP-HIP-KNEE measure beginning with the FFY 2027 program year; and (2) the five National Healthcare Safety Network ("NHSN") Healthcare-Associated Infection ("HAI") measures beginning with the FFY 2027 program year.[31] CMS also finalized newly established performance standards for certain measures for the program years in FFY 2027 through FFY 2031.[32] CMS additionally finalized updates to the ECE regulations to specify that an ECE could take the form of an extension of time for a hospital to comply with a data reporting requirement, if appropriate under the circumstances.[33] Specifically, CMS amended its regulations so that it 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 (i.e., a natural or man-made disaster, terrorist attack, etc.)—that affected the ability of the hospital to comply with one or more applicable reporting

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[24] 90 Fed. Reg. 36923.
[25] *Id*.
[26] 90 Fed. Reg. 36931.
[27] 90 Fed. Reg. 36932.
[28] 90 Fed. Reg. 36942.
[29] 90 Fed. Reg. 36949.
[30] 90 Fed. Reg. 36943.
[31] 90 Fed. Reg. 36949; 90 Fed. Reg. 36540.
[32] 90 Fed. Reg. 36537.
[33] *Id*.

requirements with respect to a fiscal year.[34] Finally, CMS is removing the health equity adjustment ("HEA") from the Hospital Value-Based Purchasing ("VBP") Program.[35]

I. Hospital-Acquired Condition Reduction Program Updates and Changes

CMS finalized technical updates to the Centers for Disease Control and Prevention ("CDC") NHSN HAI measures and updates to the ECE policy for the Hospital-Acquired Condition Reduction Program ("HAC Reduction Program"), to go into effect on October 1, 2025. CMS finalized its proposal to update and codify the ECE policy to clarify that it has the discretion to grant either an exemption from, or an extension of time to meet, reporting requirements in response to ECE requests when hospitals are affected by events beyond their control, such as natural disasters.[36] After consideration of public comments regarding the proposed timeframe in which a hospital may request an ECE, CMS finalized a different timeframe, allowing up to 60 days for hospitals to submit an ECE request after the precipitating event.[37] Additionally, CMS is updating the NHSN HAI chart-abstracted measures, transitioning to a new 2022 baseline for the standard population data used in standardized infection rations ("SIR") calculations, which will be phased in starting with infections reported in 2025 and fully implemented for the HAC Reduction Program in FFY 2028.[38] These updates are made under section 1886(p) of the Act, which mandates the reduction of payments to hospitals with high rates of hospital-acquired conditions. According to CMS, the proposed changes are designed to be budget neutral, ensuring that the overall financial impact on hospitals remains unchanged.

J. Toward Digital Quality Measurement in CMS Quality Programs – Request for Information

In the proposed IPPS rule, CMS sought public input on the transition to digital quality measurement ("DQM") for CMS programs. Specifically, CMS sought comments on its anticipated use of Health Level Seven® Fast Healthcare Interoperability Resources® ("FHIR") in electronic clinical quality measure ("eCQM") reporting in CMS programs, including the Hospital Inpatient Quality Reporting ("IQR") Program, the Hospital Outpatient Quality Reporting ("OQR") Program, and the Medicare Promoting Interoperability Program. CMS, along with the CDC, is working to transition to fully automated digital quality measures by developing new measures to address patient safety gaps and updating current measures to an FHIR-based format. The final rule notes that any substantive updates to program-specific requirements related to providing data for quality measurement and reporting would be addressed through future notice-and-comment rulemaking, as necessary.[39]

K. Requirements for and Changes to the Hospital Inpatient Quality Reporting Program

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[34] 90 Fed. Reg. 36942.
[35] 90 Fed. Reg. 36963.
[36] 90 Fed. Reg. 36966.
[37] *Id*.
[38] 90 Fed. Reg. 36965.
[39] *90 Fed. Reg. 36991*.

CMS finalized modifications to four existing quality measures and the removal of four measures to improve quality reporting and safety practices across hospitals.[40] Specifically, CMS modified the following two measures to add Medicare Advantage patients to the current cohort of patients, shorten the performance period from three to two years, and change the risk adjustment methodology: (1) the Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty and (2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity.[41] Additionally, CMS proposes to modify (3) the Hybrid Hospital-Wide Readmission and (4) Hybrid Hospital-Wide Mortality measures to lower the submission thresholds.[42] The four measures to be removed beginning with the CY 2024 reporting period/FFY 2026 payment determination include the (1) Hospital Commitment to Health Equity, (2) COVID-19 Vaccination Coverage among Health Care personnel Measure, and measures of (3) the Screening for Social Drivers of Health and (4) the Screen Positive Rate for Social Drivers of Health.[43] Finally, CMS finalized its update to the ECE policy to clarify that CMS has the discretion to grant an extension rather than only a full exception in response to ECE requests.[44]

L. Changes to the Long-Term Care Hospital Quality Reporting Program

Pursuant to Section 1886(m)(5) of the Act, which mandates the establishment of quality reporting requirements for long-term care hospitals, CMS finalized several changes to the LTCH Quality Reporting Program ("LTCH QRP").[45] Beginning with patients admitted on or after October 1, 2026, CMS will exclude expired LTCH patients from the COVID-19 Vaccine reporting requirements by removing the need to submit item O0350 for these patients on the LTCH Continuity Assessment Record and Evaluation Data Set.[46] Furthermore, CMS amended the reconsideration policy and process to provide clearer guidelines and greater flexibility for LTCHs seeking to challenge noncompliance determinations under the LTCH QRP.[47] Additionally, CMS finalized its proposal to remove four Social Determinants of Health ("SDOH") standardized patient assessment data elements beginning with the FFY 2028 LTCH QRP, specifically the items for Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330).[48]

M. Low wage index policy

CMS will discontinue the low wage index hospital policy, for FFY 2026 (beginning October 1, 2025) and subsequent fiscal years, in alignment with the D.C. Circuit's decision in *Bridgeport Hosp. v. Becerra*, Case No. 22-5249.[49] In 2019, CMS adopted a wage index

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[40] 90 Fed. Reg. 37301.
[41] *Id*.
[42] *Id*.
[43] *Id*.
[44] 90 Fed. Reg. 36540.
[45] 90 Fed. Reg. 37032.
[46] 90 Fed. Reg. 37034.
[47] 90 Fed. Reg. 37039.
[48] 90 Fed. Reg. 37037.
[49] 90 Fed. Reg. 37213.

redistribution policy, under which HHS would increase the wage index value for low-wage hospitals and apply a budget neutrality factor for all other hospitals. Under the low wage index hospital policy, CMS would increase the wage index for hospitals with a wage index below the 25th percentile wage index value by half the difference between the otherwise applicable final wage index value and the 25th percentile wage index value for that year. On July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under the Medicare statute "to adopt the low wage index hospital policy for [F]FY 2020," and that the policy and related budget neutrality adjustment must be vacated. In response, on October 3, 2024, CMS released an interim final action with comment period, in which it recalculated the FFY 2025 IPPS hospital wage index to remove the low wage index hospital policy for FFY 2025. CMS will now discontinue the policy for FFY 2026 and all subsequent federal fiscal years. In addition, CMS is adopting a transitional exception policy applicable to hospitals that will be "significantly impacted" by the discontinuation of the low wage index hospital policy (i.e., the hospital's proposed FFY 2026 wage index is decreasing by more than 9.75% from the hospital's FFY 2024 wage index). For such a hospital, the transitional payment exception for FFY 2026 would be equal to the additional FFY 2026 amount the hospital would be paid under the IPPS if its FFY 2026 wage index were equal to 90.25% of its FFY 2024 wage index.[50] Unlike the prior interim transitional policy, which CMS instituted for FFY 2025, the transitional payment exception would be made budget neutral through an adjustment applied to the standardized amount for all hospitals.[51] This represents a change from the FFY 2025 policy, which was not budget neutral.

N. Changes to the Medicare Promoting Interoperability Program

CMS finalized its proposal that eligible health care professionals, such as hospitals and Critical Access Hospitals ("CAHs"), use Certified EHR Technology ("CEHRT") under the Medicare Promoting Interoperability Program and the Merit-Based Incentive Payment System.[52] For FFY 2026, CMS is imposing several changes. First, eligible hospitals and CAHs would report on their Electronic Health Record ("EHR") use for at least 180 days in a row in any calendar year.[53] Second, eligible hospitals and CAHs must attest "Yes" to both security risk analysis and security risk management for their EHRs.[54] Third, eligible hospitals and CAHs must attest "Yes" to using all eight 2025 SAFER Guides to assess their EHRs every year.[55] Finally, CMS finalized a bonus measure for the Public Health and Clinical Data Exchange objective for data exchange with a Public Health Agency ("PHA") using the Trusted Exchange Framework and Common Agreement ("TEFCA").[56] Eligible hospitals and CAHs could get up to five bonus points for sharing data with a PHA.[57]

O. Changes to the Transforming Episode Accountability Model

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[50] 90 Fed. Reg. 36539.
[51] *Id*.
[52] 90 Fed. Reg. 36537.
[53] 90 Fed. Reg. 37045.
[54] 90 Fed. Reg. 37048.
[55] 90 Fed. Reg. 37051.
[56] 90 Fed. Reg. 37056.
[57] 90 Fed. Reg. 37056.

The Transforming Episode Accountability Model ("TEAM") is a mandatory, episode-based alternative payment model for acute care hospitals. Under TEAM, select acute care hospitals will take responsibility for the cost and quality of care from hospital-based surgeries through the first 30 days after the patient's surgery. TEAM will run from January 1, 2026 to December 31, 2030 and test five specific surgical episode categories: Coronary Artery Bypass Graft Surgery; Lower Extremity Joint Replacement; Major Bowel Procedure; Surgical Hip/Femur Fracture Treatment; and Spinal Fusion. Under the authority of Section 115A of the Act, CMS finalized various changes to TEAM in advance of its implementation, including (1) a limited deferment period for certain hospitals; (2) addressing the expiration of the MDH program; (3) excluding Indian Health Service ("IHS") hospitals from TEAM participation; (4) adding the Information Transfer Patient Reported Outcome-based Performance Measure ("Information Transfer PRO-PM"); (5) applying a neutral quality measure score for TEAM participants with insufficient quality data; (6) a methodology to construct target prices when there are coding changes; (7) reconstructing the normalization factor and prospective trend factor; (8) replacing the Area Deprivation Index ("ADI") with the Community Deprivation Index ("CDI"); (9) using a 180-day lookback period and Hierarchical Condition Categories ("HCC") version 28 for beneficiary risk adjustment; (10) eliminating downside financial risk for low volume hospitals; (11) aligning the date range used for episode attribution; (12) removing health equity plans and health related social needs data reporting; (13) broadening the Skilled Nursing Facility ("SNF") 3-day rule waiver; (14) modifying the referral to primary care services requirement; and (15) removing the Decarbonization and Resilience Initiative ("DRI").[58] These changes will go into effect on October 1, 2025.

II. 2026 OPPS Proposed Rule

On July 17, 2025, the CMS published in the Federal Register its CY 2026 OPPS proposed rule. Comments on these proposals were due to CMS by September 15, 2025.

A. Payment Rate Updates

For CY 2026, CMS is proposing an overall increase factor of 2.4 percent to the OPPS conversion factor.[59] This 2.4 percent increase is the result of a 3.2 percent increase to the market basket percentage, which is based on the most recent estimate of the inpatient market basket calculation, offset by a 0.8 percent decrease to the multifactor productivity adjustment.[60] CMS estimates that total payments to OPPS providers for CY 2026 would be approximately $100 billion, $8.1 billion more than estimated CY 2025 OPPS payments.[61] Hospitals failing to meet outpatient quality reporting requirements will continue to receive a 2.0 percentage point reduction in payments.[62] Furthermore, CMS proposes that Ambulatory Surgical Center ("ASC") payment rates likewise increase by 2.4 percent for ASCs meeting quality reporting

[58] 90 Fed. Reg. 36541.
[59] 90 Fed. Reg. 33476, 33479.
[60] *Id.*
[61] *Id.*
[62] *Id.*

requirements.[63] Total payments to ASCs are projected at $9.2 billion, up $480 million from CY 2025.[64]

B. Policy and Payment Methodology

CMS proposes to expand the ASC Covered Procedures List ("CPL") by revising criteria and eliminating five exclusion criteria, moving them to a new section as nonbinding physician considerations for patient safety.[65] Two-hundred and seventy-six procedures are proposed for addition to the ASC CPL, along with 271 others that are proposed for removal from the Inpatient Only ("IPO") list.[66] The IPO list is proposed to be phased out completely over the next three years, starting with the removal of 285 primarily musculoskeletal services in CY 2026.[67] CMS seeks comments as to whether the three-year timeline is realistic and whether other services should be removed first (as opposed to musculoskeletal services).[68] For CY 2026, CMS proposes to continue indefinitely exempting procedures removed from the IPO list from certain medical review activities related to the two-midnight rule.[69] Specifically, these procedures will not be subject to site-of-service claim denials, Recovery Audit Contractor ("RAC") referrals, or RAC reviews for "patient status" until claims data show they are more commonly performed outpatient.[70] CMS notes that this gives providers time to adjust and ensures quality of care is maintained during the transition away from the IPO list.[71]

C. Hospital Price Transparency

Pursuant to Executive Order 14221 ("Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information"), CMS has proposed a series of amendments to hospital price transparency regulations.[72] Under these amendments, hospitals would be required to report the 10th percentile, median, and 90th percentile allowed amounts, as well as the count of allowed amounts, when payer-specific negotiated charges are determined by percentages or algorithms.[73] Hospitals would need to use EDI 835 electronic remittance advice data to calculate these values.[74] Additionally, hospitals must attest to the accuracy and completeness of the data in a machine-readable file ("MRF") and encode the name of the chief executive officer or other designated official.[75] Hospitals would also be required to report their National Provider Identifiers in the MRF.[76] CMS further proposes

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[63] 90 Fed. Reg. 33476, 33753.
[64] 90 Fed. Reg. 33476, 33479.
[65] 90 Fed. Reg. 33476, 33480.
[66] *Id.*
[67] *Id.*
[68] 90 Fed. Reg. 33476, 33669.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] 90 Fed. Reg. 33476, 33489.
[73] 90 Fed. Reg. 33476, 33483.
[74] 90 Fed. Reg. 33476, 33795.
[75] 90 Fed. Reg. 33476, 33799.
[76] 90 Fed. Reg. 33476, 33800.

allowing a 35 percent reduction in civil monetary penalties for hospitals that waive their right to an Administrative Law Judge hearing.[77]

D. Quality Reporting Programs

The proposed rule removes several measures from the Outpatient, Rural Emergency Hospital ("REH"), and ASC Quality Reporting Programs, including COVID-19 Vaccination Coverage Among Healthcare Personnel, Commitment to Health Equity, and Screening for Social Drivers of Health.[78] CMS proposes to add the Emergency Care Access & Timeliness electronic clinical quality measure ("eCQM") to the Outpatient and REH programs.[79] For the ASC program, a new patient-reported outcome measure on understanding recovery information is proposed.[80] The Excessive Radiation Dose eCQM will remain voluntary.[81] CMS also proposes updating its Extraordinary Circumstances Exception policy to allow extensions of reporting times in events of uncontrollable circumstances, such as natural disasters or technological issues with data collection systems.[82]

E. Hospital Quality Star Ratings

CMS proposes a two-stage update to the Hospital Quality Star Ratings to emphasize patient safety.[83] In 2026, hospitals in the lowest quartile for Safety of Care (with at least three safety measures) will be capped at a maximum of four stars, even if their overall score would otherwise qualify them for five.[84] Beginning in 2027, hospitals in the lowest quartile for Safety of Care will have their star rating reduced by one, to a minimum of one star.[85] According to CMS, these changes ensure hospitals with poor safety performance cannot achieve the highest ratings, and the methodology remains transparent and responsive to stakeholder input.[86] CMS invites public comment on these proposals.[87]

F. Non-Drug Items and Services

CMS proposes to revise the prospective offset of increased payments for non-drug items and services made from CY 2018 through CY 2022 due to the 340B Payment Policy.[88] Beginning in CY 2026, the OPPS conversion factor for non-drug items and services will be reduced by 2 percent per year (instead of the previously finalized 0.5 percent), until the total offset reaches $7.8 billion—which CMS estimates will take about 6 years.[89] This reduction will

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[77] 90 Fed. Reg. 33476, 33482.
[78] 90 Fed. Reg. 33476, 33480.
[79] *Id*.
[80] *Id*.
[81] *Id*.
[82] 90 Fed. Reg. 33476, 33756.
[83] 90 Fed. Reg. 33476, 33786.
[84] *Id*.
[85] *Id*.
[86] *Id*.
[87] 90 Fed. Reg. 33476, 33789.
[88] 90 Fed. Reg. 33476, 33632.
[89] 90 Fed. Reg. 33476, 33635.

not apply to hospitals that enrolled in Medicare after January 1, 2018.[90] The change aims to restore hospitals to their financial position had the 340B policy not been implemented, while avoiding a disruptive, one-time recoupment.[91] CMS is also considering a 5 percent annual reduction as an alternative, which would reach the offset in about 3 years.[92] The offset will not affect ASC payment rates, which will be based on OPPS rates for new providers.[93] CMS states that this approach balances budget neutrality requirements with minimizing financial disruption for hospitals.[94]

G. Skin Substitute Products

Beginning January 1, 2026, CMS proposes to separately pay for skin substitute products under the OPPS as incident-to supplies, rather than packaging payment with the administration procedure.[95] Skin substitutes will be grouped into three new Ambulatory Payment Classifications ("APCs") based on FDA regulatory categories: (1) PMA; (2) 510(k); and (3) 361 HCT/P.[96] The initial payment rate for all three APCs is proposed at $125.38 per unit, calculated using volume-weighted average ASP data from Q4 2024, and updated annually.[97] CMS seeks comments on these proposed rates.[98] All existing HCPCS codes for skin substitutes will be assigned a new status indicator "S1" for separate payment.[99] Unlisted HCPCS codes will be created for new products lacking specific codes.[100] Biologicals licensed under section 351 of the Public Health Service Act will continue to be paid under the ASP methodology.[101] CMS seeks comments on possible subcategories within FDA groupings and inclusion of products not in sheet form.[102]

H. Excepted Off-Campus Provider-Based Departments ("PBDs")

For CY 2026, CMS proposes to pay drug administration services at excepted off-campus PBDs at the lower PFS rate—40 percent of the OPPS rate—instead of the higher OPPS rate.[103] Rural Sole Community Hospitals are exempt to control the volume of drug administration services.[104] CMS estimates this change will reduce Medicare payments by $210 million and Medicaid beneficiary coinsurance payments by $70 million in 2026.[105] The agency is also seeking information on expanding this approach to on-campus clinic visits.[106]

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[90] 90 Fed. Reg. 33476, 33633.
[91] 90 Fed. Reg. 33476, 33634.
[92] 90 Fed. Reg. 33476, 33635.
[93] 90 Fed. Reg. 33476, 33637.
[94] 90 Fed. Reg. 33476, 33635.
[95] 90 Fed. Reg. 33476, 33643.
[96] 90 Fed. Reg. 33476, 33644.
[97] 90 Fed. Reg. 33476, 33647.
[98] *Id*.
[99] 90 Fed. Reg. 33476, 33648.
[100] 90 Fed. Reg. 33476, 33649.
[101] 90 Fed. Reg. 33476, 33643.
[102] 90 Fed. Reg. 33476, 33646.
[103] 90 Fed. Reg. 33476, 33656.
[104] 90 Fed. Reg. 33476, 33481.
[105] 90 Fed. Reg. 33476, 33690.
[106] 90 Fed. Reg. 33476, 33481.

I. Graduate Medical Education ("GME") Accreditation

In accordance with Executive Order 14279 ("Reforming Accreditation to Strengthen Higher Education"), CMS proposes that, effective January 1, 2026, GME accrediting organizations may not require or encourage diversity, equity, and inclusion programs that promote unlawful discrimination based on race or other violations of federal law.[107] The Secretary may also recognize other accrediting organizations to increase competition and improve quality in the accreditation process.[108]

J. Software as a Service ("SaaS")

CMS is soliciting public input on developing consistent and appropriate payment policies for SaaS technologies under OPPS.[109] The agency seeks feedback on factors for setting payment rates, cost assessment, what data sources to use to establish rates, and how to reflect the costs of SaaS.[110] CMS intends to use this feedback to determine whether it needs to adjust its SaaS payment policies to ensure more accurate payment across settings of care.[111]

K. Site Neutral Payments

CMS proposes to expand site neutral payment to drug administration services provided in grandfathered (excepted) off-campus hospital outpatient departments ("HOPDs") (with an exemption for sole community hospitals). CMS estimates that the site neutral rate – 40% of the OPPS rate – at a site-neutral rate will reduce OPPS spending by $280 million. The agency also sought public comments on expanding site-neutral payment policies to include on-campus clinic visits.

III. 2026 PFS Proposed Rule

On July 16, 2025, CMS published in the Federal Register its annual proposed rule for the CY 2026 PFS. Comments on these proposals were due to CMS by September 12, 2025.

A. Conversion Factor

For CY 2026, CMS is proposing an overall conversion factor of $33.5875 for physicians meeting advanced alternative payment model participation thresholds and $33.4209 for other clinicians.[112] These are increases of 3.8% and 3.3% respectively, from the final CY 2025 conversion factor of $32.3465. This is the first increase in the conversion factor in over five years, and reflects a one-year 2.5% update enacted under the One Big Beautiful Bill Act, a permanent 0.75% update, and a 0.55% budget neutrality adjustment.[113]

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[107] 90 Fed. Reg. 33476, 33811-12.
[108] *Id*.
[109] 90 Fed. Reg. 33476, 33564.
[110] 90 Fed. Reg. 33476, 33565.
[111] 90 Fed. Reg. 33476, 33481.
[112] 90 Fed. Reg. 32800.
[113] *Id*.

B. Efficiency Adjustment

However, CMS is also proposing a new efficiency adjustment to the work relative value units ("RVUs") as well as corresponding updates to the interservice portion of physician time inputs for non-time-based services, which will, for some clinicians, negatively impact the higher payment adjustment.[114] The proposed efficiency adjustment ins a reduction of 2.5% for allotted codes, and the efficiency adjustment would be applied every three years, with the next efficiency adjustment to be calculated and applied in CY 2029.[115] CMS proposes that the public be able to submit nominations via the "Potentially Misvalued Codes" process, "if they believe the efficiency adjustment will lead to inaccurate physician time and work RVUs for a particular code."[116]

C. Practice Expense Methodology

CMS has proposed revising the methodology for allocating indirect practice expense ("PE") costs for facility-based services, proposing to reduce the portion of PE RVUs allocated based on work RVUs in the facility setting to half the amount used in the non-facility setting.[117] This would reduce the PE component of RVUs for clinicians working in facilities but would result in increases in overall PFS spending for many office-based specialties "including surgical specialties, primary care specialties, behavioral health specialties, and those who furnish highly technical services outside of the hospital setting reflect significant increases relative to most of those same specialties in the facility setting."[118]

D. Telehealth

CMS is proposing changes to the present five-step process for making additions, deletions, or changes to the Medicare Telehealth Services List.[119] CMS presently reviews codes using a five-step process, after which codes are assigned "provisional" or "permanent" status on the Medicare Telehealth Services List.[120] CMS is proposing to eliminating steps four and five, which would result in any service added to the Medicare Telehealth Services List being included on a permanent basis, removing the "permanent" versus "provisional" distinction.[121] If the proposal is finalized, all codes presently on the provisional list would be added to the permanent list.[122] Examples of codes that had been considered "provisional" in CY 2025 include psychophysiological therapy, comprehensive hearing test, and speech/hearing therapy.[123] CMS is also proposing to permanently allow direct supervision via combined audio/video real-time

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[114] 90 Fed. Reg. 32401.
[115] 90 Fed. Reg. 32402; 90 Fed. Reg. 32403
[116] 90 Fed. Reg. 32403.
[117] 90 Fed. Reg. 32357.
[118] 90 Fed. Reg. 32806.
[119] 90 Fed. Reg. 32387.
[120] *Id*.
[121] *Id*.
[122] *Id*.
[123] *See* CMS, List of Telehealth Services for Calendar Year 2025 (Dec. 11, 2024).

communications technology for most incident-to services under Section 410.26 starting January 1, 2026.[124]

E. Expanded Coverage for Digital Mental Health Treatment

CMS is proposing to expand coverage of Digital Mental Health Treatment ("DMHT") devices furnished incident to professional behavioral health services used in conjunction with ongoing treatment under a behavioral health treatment plan of care.[125] Specifically, CMS is proposing to expand payment policies for specific codes to allow payment for DMHT devices for ADHD.[126] CMS has also been reviewing recommendations for [payment for FDA authorized devices under other classifications, including computerized behavioral therapy device for treating symptoms of gastrointestinal conditions and therapy device to reduce sleep disturbances for psychiatric conditions, among others.[127]

F. Merit-Based Incentive Payment System

CMS is proposing updates to the Merit-based Incentive Payment System ("MIPS") Value Pathways ("MVPs"), proposing six new MVPs for the 2026 CY, focusing on diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery.[128] This would bring the MVP total to 27.[129] CMS also proposes maintaining the MIPS performance threshold of 75 points through cost year 2028/2030 MIPS payment year.[130]

G. New Mandatory Ambulatory Specialty Model

CMS is also proposing the implementation and testing of the Ambulatory Specialty Model ("ASM"), which would be a new mandatory alternative payment model with five performance years that would begin January 1, 2027.[131] In an effort to enhance quality of care and lower the costs of care, ASM would be established as a mandatory model focused on the care provided by specialists to beneficiaries with chronic conditions of heart failure and low back pain.[132] Clinicians would be required to report a select set of measures and activities clinically relevant to their specialty type and the chronic condition of interest in order to assess quality, cost, interoperability, and care coordination practices.[133] The ultimate goal of this proposal is to improve beneficiary and provider engagement, incentivize preventive care, and increase financial accountability for certain specialists.[134]

H. Requests for Information

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[124] 90 Fed. Reg. 32395, 32396.
[125] 90 Fed. Reg. 32503.
[126] 90 Fed. Reg. 32504.
[127] 90 Fed. Reg. 32503, 32504.
[128] 90 Fed. Reg. 32696.
[129] 90 Fed. Reg. 32704.
[130] 90 Fed. Reg. 32698.
[131] 90 Fed. Reg. 32558.
[132] *Id*.
[133] *Id*.
[134] *Id*.

The agency solicits public input on a number of topics, including Executive Order 14192 "Unleashing Prosperity Through Deregulation,"[135] as well as feedback on how to enhance support management for prevention and management of chronic disease.[136]

[135] 90 Fed. Reg. 32353.
[136] 90 Fed. Reg. 32507.