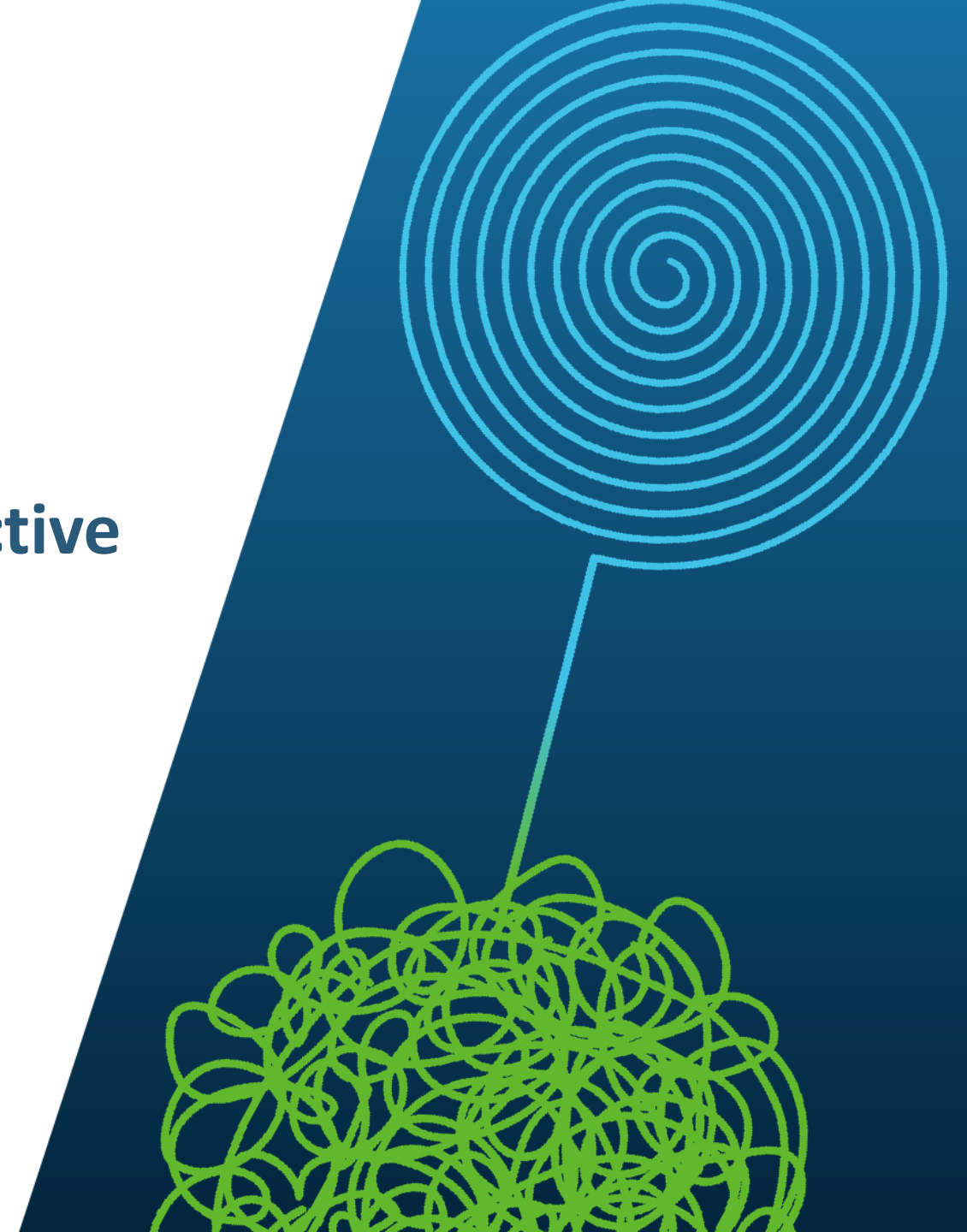
Healthcare Regulatory Roundup #104

2026 Hospital Outpatient Prospective Payment System Final Rule

November 25, 2025



Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
  - If question not addressed during webinar, will follow-up via e-mail
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Introductions

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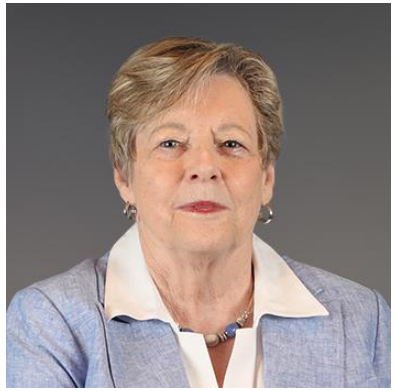

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Today's Agenda

1. Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026
2. 2026 Medicare Premiums and Deductibles
3. 2026 OPPS Final Rule
4. 2026 End-Stage Renal Disease Prospective Payment System Final Rule
5. 2026 Home Health Prospective Payment System Final Rule

1. Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026

Retroactive Extensions

- Extended from October 1, 2025, to January 30, 2026
  - COVID-19 era telehealth waivers
    - DEA posted Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications
  - Medicare Dependent Hospital and Low Volume Hospital Programs
  - Community Health Center Fund
  - Medicare Physician Fee Schedule GPCI floor
  - Ambulance add-on payments
  - Acute hospital care at home (AHCH) waivers
  - Delay in Medicaid Disproportionate Share Hospital payment reductions
- Processing/re-processing claims for services rendered during shutdown
  - CMS instructed MACs “to perform mass adjustments to any paid claims that are inconsistent” with retroactive extension
  - Providers should re-submit telehealth claims denied with message CARC 16 and RARC M77
  - Hospitals may re-submit denied AHCH claims (but CMS instructed hospitals to stop admitting new patients under AHCAH waiver and either discharge or transfer existing patients back to brick-and-mortar facilities)

Sequestration

Section 8001(d):

- PAYGO scorecard to be set at zero as of date of adjournment of first session of 119th Congress

Impact:

- OBBBA's $3.4 trillion in deficit spending over next 10 years will NOT trigger 2% increase in sequestration
  - Current 2% sequestration extended + $400 million cut to Medicare Improvement Fund to pay for "minibus" bill

What's Ahead

- Vote on extension of ACA enhanced premium tax credits in December
  - **Absent extension, ~4.8 million will lose coverage and millions more will pay significantly higher premiums**
- 66 days (42 working days) to fund remaining programs from January 31 to September 30, 2026, including extensions of enhanced Medicare payments and delay in Medicaid DSH cuts
  - *Another* continuing resolution to maintain FY 2025 spending levels for remaining programs?

2. CY 2026 Medicare Premiums & Deductibles

Released November 14, 2025

Higher Medicare Out-of-Pocket Costs in 2026

- Part A deductible and co-insurance
  - Hospital: deductible increasing from $1,676 to $1,736 (1st 60 days); daily co-insurance paid after 60 days increasing from $419/day to $434/day in a benefit period and from $838/day to $868/day for lifetime reserve days
  - SNF: daily co-insurance for days 21-100 increasing from $209.50/day to $217/day
- Part B
  - Standard monthly premium paid by all Medicare beneficiaries increasing by ~10%, from $185 to $202.90
    - ~30% MA plans offer premium rebate (most < $100)
    - CMS: Would have been $11 more per month absent changes to skin substitute coverage
    - Income-related monthly adjustment amounts for Part B premium also increasing by ~10%
  - Annual deductible also increasing by 10%, from $259/year to $283/year
- Likely increases in Medicare supplemental insurance rates

3. 2026 OPPS Final Rule

Released November 21, 2025

CY 2026 Payment Changes

- 2.6% increase to OPPS conversion factor (vs. proposed 2.4% increase)
  - From $89.169 to $91.415
  - Hospital inpatient market basket increase of 3.3% less productivity adjustment of 0.7%
  - Statutory 2.0 percentage point reduction for hospitals that do not meet quality reporting requirements
- Outlier threshold reduced from $7,175 to $6,225
  - Even more than Proposed Rule ($6,450)
- 2026 ASC conversion factor = $56.322 (61.61% of OPPS conversion factor)
  - Continue using hospital market basket update as update factor for ASC payment system
  - Statutory 2.0 percentage point reduction for ASCs not meeting quality reporting requirements

2026 Conversion Factor Calculation

TABLE 8: CALCULATION OF CY 2026 FINAL OPPS CONVERSION FACTOR

Start: CY 2025 Final OPPS Conversion Factor = **$89.169**

Step 1a: Adjust the conversion factor to temporarily account for additional drug and device pass-through spending and outlier spending in CY 2025. This action causes an increase in the conversion factor. So, the amount of both drug and device pass-through spending (0.0037) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2025.

- 1.0000 – (0.0037 + 0.01) = 0.9863

Step 1b: Divide $89.169 by 0.9863

- $89.169/0.9863 = **$90.408**

Step 2: Adjust the conversion factor by the required wage index budget neutrality adjustment of approximately 0.9990. This adjustment increases the amount of OPPS outpatient hospital spending and is multiplied with $90.408.

- $90.408* 0.9990 = **$90.317**

Step 3: Adjust the conversion factor by the 5 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9955. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $91.456.

- $90.317* 0.9995 = **$90.272**

Step 4: Adjust the conversion factor by the cancer hospital payment adjustment of 1.0000. Because the PCR for cancer hospitals is the same between CY 2025 and CY 2026, there would be no change to the OPPS conversion factor.

- $90.272*1.0000 = **$90.272**

Step 5: Adjust the conversion factor by rural SCH adjustment policy of 1.0000. Since we propose to maintain our current policy, there is no impact on the conversion factor by this policy.

- $90.272*1.0000 = **$90.272**

Step 6a: Adjust the conversion factor by the OPD fee schedule increase factor of 0.026 for CY 2026. The OPD fee schedule increase factor increases outpatient hospital spending in CY 2026 over CY 2025 and is added to 1.0000 which represents total outpatient hospital OPPS spending in CY 2025.

- 1.0000+0.026 = 1.0260

Step 6b: Multiply $90.272 by 1.0260.

- $90.272*1.0260 = **$92.619**

Step 7a: Adjust the conversion factor to remove additional drug and device pass-through spending and outlier spending for CY 2026. This action causes a decrease in the conversion factor. So, the amount of both drug and device pass-through spending (0.0030) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2026.

- 1.0000 – (0.0030+0.01) = 0.9870

Step 7b: Multiply $92.619 by 0.9870 to get the CY 2026 final OPPS conversion factor.

$92.619*0.9870 = **$91.415**

Finish: **CY 2026 OPPS Conversion Factor = $91.415**

* *Reduction for Providers Subject to the 340B Remedy Offset*

Step 8: Multiply $91.415 by 0.9951 to get the CY 2026 final OPPS conversion factor for the providers subject to the 340B remedy offset.

$91.415*0.9951 = **$90.967**

Please note rounding may affect the numbers in the calculations above.

OPPS 340B "Remedy"

- **Proposed rule**:
  - Increase reduction to OPPS conversion factor from 0.5% to 2% for non-drug items and services and reduce pay-back period from 16 to 6 years
    - Would have reduced conversion factor by $1.789

- **Final rule**:
  - Will stay at 0.5% **for CY 2026 only**
    - Reduces conversion factor by $0.448 to $90.967 for non-drug items and services
    - Anticipate more significant reduction (up to 2%) in CY 2027 and beyond
  - **Not applicable to hospitals enrolled in Medicare after 01/01/2018 (*will receive full payment update*)**

Lesson: Comments work!

R.I.P. IPO

- Phase out Inpatient Only list (IPO) over 3 years starting in CY 2026
- Remove 285 mostly musculoskeletal services for CY 2026
- Continue policy exempting procedures removed from IPO from two-midnight policy review until claims data shows procedures more commonly billed in outpatient setting
- Corresponding changes to ASC Covered Procedures List (CPL)
  - Revised criteria for adding services to CPL – additional 289 codes
    - Physician discretion
  - Additional codes due to removal from IPO – additional 271 codes

Medicare OPPS Drug Acquisition Cost Survey

- April 15 Executive Order "Lowering Drug Prices by Once Again Putting Americans First"
  - "Within 180 days…the Secretary shall publish in the Federal Register a plan to conduct a survey…to determine the hospital acquisition cost for covered outpatient drugs at hospital outpatient departments."
- CMS to survey acquisition costs for each separately payable drug acquired by all hospitals and paid under OPPS
  - Submission window opening early CY 2026
- CMS wants to use the data for CY 2027 OPPS NPRM
- Cannot force hospitals to complete the survey but may consider non-responses in future rate reductions

Site Neutral Payment Reform – Drug Administration

- **General rule:** payment rates for services performed in on-campus and excepted off-campus HOPDs are higher than rates for same service performed in physician clinic due to different cost structures
  - Excepted off-campus HOPD = operating prior to 11/02/2015
- **2019:** apply MPFS equivalent payment rate for clinics visits (HCPCS G0463) performed in ***excepted*** off-campus HOPD
  - Phased in over 2 years in non-budget neutral manner; exemption for rural sole community hospitals
  - MPFS equivalent rate = 40% of HOPD rate
- **2026:** apply MPFS equivalent payment rate for 61 HCPCS codes assigned to drug administration APCs (5691-94) performed in exempt off-campus HOPD
  - Implement in non-budget neutral manner; exemption for rural sole community hospitals
  - Estimated $280 million in savings in 2026 ($70 million in reduced beneficiary coinsurance)

https://www.pyapc.com/insights/hcrr-90-webinar-tightening-your-belt-prepare-for-site-neutral-payment-reforms/

Skin Substitutes

- Historically, CMS has unconditionally packaged skin substitute products furnished in HOPDs into their associated application procedure
- Beginning in 2026, will unpackage most skin substitute products and reimburse under 3 newly-established APCs
  - All 3 APCs reimbursed at flat, standardized national rate of ~$127/cm; separate payment for application of skin substitute
    - HCPCS C-codes describing the low-cost group (HCPCS codes C5271-C5278) will be deleted, while high-cost group HCPCS codes (15271-15278) will be preserved, to describe application procedures
  - Exception for products licensed as biologics under Section 351 of the Public Health Service Act

Virtual Supervision

- Permanent virtual supervision of cardiac rehab, intensive cardiac rehab, and pulmonary rehab services and diagnostic services
  - Provider required supervision via audio-visual real-time communications technology (**audio-only not sufficient**)
  - Excludes diagnostic services with global period indicator of 010 or 090

Price Transparency

- New requirements effective January 1, 2026; enforcement delayed to April 1, 2026:
  - Requires reporting of actual payment amounts when standard “charges” are based on percentages or algorithms
    - Report real dollar “costs”
    - Requires disclosure of 10th percentile, median, and 90th percentile allowed amounts in MRF
    - Also requires hospital to calculate and encode count of allowed amounts used to calculate encoded amounts
    - Requires that hospitals use EDI 835 ERA or an alternative, equivalent source of remittance data
    - Defines look-back period as no less than 12 months and no longer than 15 months prior to posting MRF
  - Requires encoding of name of CEO, president, or senior hospital official designated to oversee reporting of true, accurate, and complete data
  - Requires encoding of active organizational (Type 2) National Provider Identifiers associated with primary taxonomy code starting with -28 (hospital) or 27 (hospital unit)
- Finalized proposal to offer 35% reduction to hospital’s CMP when it waives right to ALJ hearing (doesn’t apply in all situations)

Revised Attestation Statement – 1/1/26

"*To the best of its knowledge and belief,* this hospital has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and the information encoded is true, accurate, and complete as of the date in the file. The hospital has included all payer-specific negotiated charges in dollars that can be expressed as a dollar amount. For payer-specific negotiated charges that cannot be expressed as a dollar amount in the machine-readable file or not knowable in advance, the hospital attests that the payer-specific negotiated charge is based on a contractual algorithm, percentage or formula that precludes the provision of a dollar amount and has provided all necessary information available to the hospital for the public to be able to derive the dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm or formula."

Outpatient Quality Reporting Program

- Adopt Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) beginning with voluntary reporting for 2027 reporting period followed by mandatory reporting beginning with 2028 reporting period/2030 payment determination
  - Remove Median Time from ED Arrival to ED Departure for Discharged ED Patients and Left Without Being Seen measures beginning with 2028 reporting period/2030 payment determination
  - Remove following measures:
    - Beginning with 2024 reporting period/2026 payment determination: COVID–19 Vaccination Coverage Among Healthcare Personnel measure
    - Beginning with 2025 reporting period/2027 payment determination
      - Hospital Commitment to Health Equity measure
      - Screening for Social Drivers of Health measure
      - Screen Positive Rate for SDOH measure

Star Rating Methodology Changes

- **For 2026 only**
  - 4-star cap for hospitals in lowest quartile of Safety of Care measure group performance
- **Beginning in 2027**
  - Blanket 1-Star reduction for hospitals in lowest quartile of Safety of Care measure group performance
    - Exemption for 1-Star hospitals
- Hospitals with fewer than 3 Safety of Care measures exempt from star rating adjustments

4. CY 2026 End-Stage Renal Disease Prospective Payment System Final Rule

Payment Changes

- Increase base rate to $281.71
  - 2.2% increase over current rate of $273.82
- Update outlier services fixed dollar loss (FDL) and Medicare allowable payment (MAP) amounts using more current data
  - Pediatric beneficiaries: FDL decrease from $234.26 to $162.48; MAP decrease from $59.60 to $50.19
  - Adult beneficiaries: FDL decrease from $45.41 to $14.30; MAP decrease from $31.02 to $23.68
- Facility-level adjustment for providers in Alaska, Hawaii and U.S. Pacific Territories to address higher non-labor costs when compared to contiguous U.S.

ESRD Quality Incentive Program (QIP)

- Changes for PY 2027
  - Remove three measures finalized in CY 2024 final rule
    - Facility Commitment to Equity
    - Screening for Social Drivers of Health
    - Screen Positive Rate for Social Drivers of Health
- Update In-Center Hemodialysis CAHPS clinical measure to 39 questions (currently 62 questions) beginning in PY 2028

5. CY 2026 Home Health Prospective Payment System Final Rule

Our Next Healthcare Regulatory Roundup Webinars

December 3, 2025; 11 am – 12 pm ET

Healthcare Regulatory Roundup #105:
CY 2026 Medicare Physician Fee Schedule Final Rule, Part 1

December 10, 2025; 11 am – 12 pm ET

Healthcare Regulatory Roundup #106:
CY 2026 Medicare Physician Fee Schedule Final Rule, Part 2

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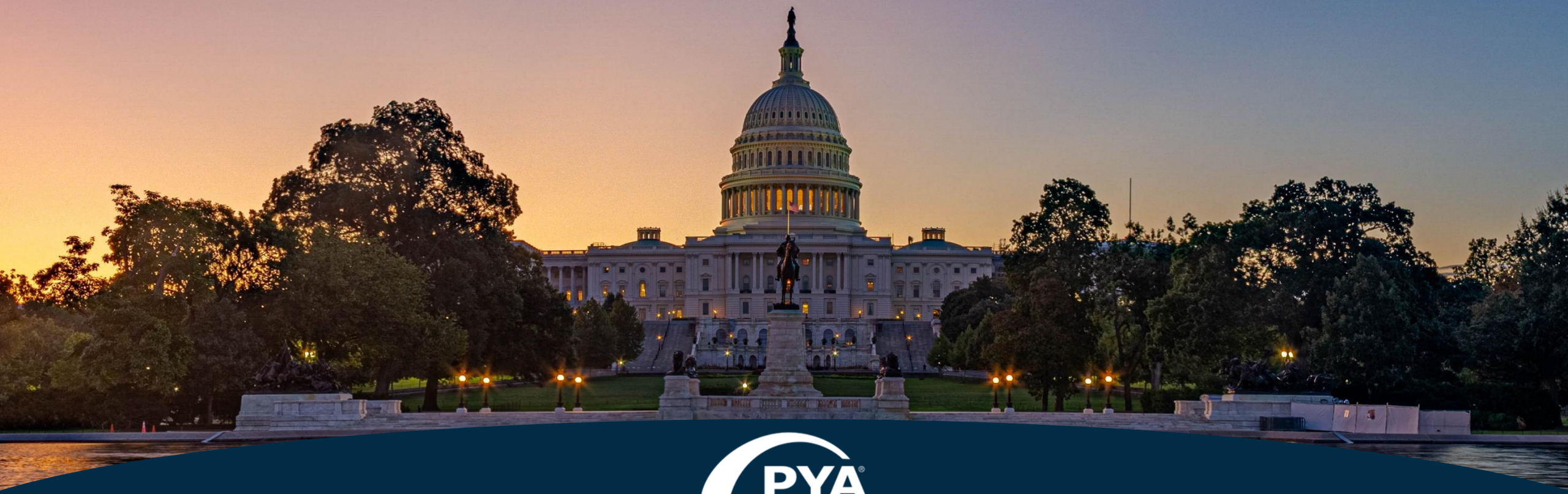

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