Calendar Year 2026 Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule: Summary and First Takes

On July 15, 2025, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that proposes updates to Medicare payment policies and rates for hospital outpatient and Ambulatory Surgical Center (ASC) services under the Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Proposed Rule for calendar year (CY) 2026.

In accordance with Medicare law, CMS proposes updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4%. This update is based on the projected hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment. For CY 2026, using the hospital market basket update, CMS proposes an update factor to the ASC rates of 2.4%. The update applies to ASCs meeting relevant quality reporting requirements. This update is based on the proposed IPPS market basket percentage increase of 3.2%, reduced by 0.8 percentage point for the productivity adjustment

- **Eliminating the Inpatient Only (IPO) List:** CMS is proposing to phase out the IPO list over a 3-year period, beginning with removing 285 mostly musculoskeletal procedures for CY 2026. CMS believes that the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time. This proposal would allow for these services to be paid by Medicare in the hospital outpatient setting when determined to be clinically appropriate, giving physicians greater flexibility in determining the most appropriate site of service.

- **Non-Opioid Treatments for Pain Relief:** CMS is proposing to continue policies to provide temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient department (HOPD) and ASC settings from January 1, 2025, through December 31, 2027, consistent with statute.

  CMS is proposing five drugs and six devices to qualify as non-opioid treatments for pain relief, and CMS proposes these products be paid separately in both the HOPD and ASC settings, starting in CY 2026.

- **Hospital Outpatient, ASC and REH Quality Reporting Programs**

  - *Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs:* CMS is proposing to remove the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the Hospital OQR and ASCQR Programs beginning with the CY 2024 Reporting Period/CY 2026 Payment Determination and to remove the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program Beginning with the CY 2025 Reporting Period/CY 2027 Payment or Program Determination. Additionally, they are proposing the removal of two Social Drivers of Health (SDOH) process measures from the Hospital OQR, REHQR, and ASCQR Programs beginning with the CY 2025 reporting period.

  - *Proposed Adoption of the Emergency Care Access & Timeliness Measure:* CMS proposes to adopt the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) in the Hospital OQR Program beginning with voluntary reporting for the CY 2027 reporting period followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination, and in the REHQR Program beginning with the CY 2027 reporting period/CY 2029 program determination as an alternative to reporting the Median

Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure. If the Emergency Care Access & Timeliness measure is finalized and adopted in the Hospital OQR Program, CMS proposes to remove the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure and the Left Without Being Seen measure, beginning with the CY 2028 reporting period/CY 2030 payment determination.

The measure, previously called the Emergency Care Capacity and Quality (ECCQ) eCQM, is specified for the hospital setting and calculates the proportion of four outcome metrics that quantify access to and timeliness of care in an ED setting against specified thresholds, including: (1) patient wait time – 1 hour; (2) whether the patient left the ED without being evaluated; (3) patient boarding time in the ED (as defined by a Decision to Admit (order) to ED departure for admitted patients) – 4 hours; and (4) patient ED LOS (time from ED arrival to ED physical departure, as defined by the ED departure timestamp) – 8 hours. An encounter is considered part of the numerator if it includes any one of the four numerator events, with events not being mutually exclusive and each contributing only once to the numerator. ED encounters with ED observation stays are excluded from components (3) and (4) but are included in the denominator. Patients who have a "decision to admit" after an ED observation stay remain excluded from criteria (3) calculations.

The results of the Emergency Care Access & Timeliness eCQM are stratified into four groups, two by age (18 years and older, and under 18 years) and two by mental health diagnoses (with, and without), an approach by which CMS believes accounts for differences between REHs without further need for risk adjustment.

ACEP has long advocated for increased measurement in order to identify, diagnose, and solve the boarding crisis. We applaud CMS for their inclusion of the measure in the OPPS proposed rule and thank CMS for their commitment in alleviating boarding in the ED.

- **Overall Hospital Quality Star Rating Proposed Modification:** CMS is proposing to update the methodology used to calculate the Overall Hospital Quality Star Rating to emphasize the contribution of the Safety of Care measure group in hospitals' ratings by implementing a 2-stage methodological update:
    - Stage 1: Implement a 4-star cap for hospitals in the lowest quartile of the Safety of Care measure group performance in Calendar Year 2026.
    - Stage 2: Implement a blanket 1-Star reduction for hospitals in the lowest quartile of Safety of Care measure group performance beginning in Calendar Year 2027.
- **Updates to Requirements for Hospitals to Make Public A List of their Standard Charges:** CMS is proposing several modifications to the Hospital Price Transparency (HPT) regulations to ensure that hospitals provide meaningful, accurate information about the amount they charge for health care items and services. CMS proposes to require, beginning January 1, 2026, hospitals disclose the tenth, median and ninetieth percentile allowed amounts in machine-readable files (MRFs) when payer-specific negotiated charges are based on percentages or algorithms as well as the count of allowed amounts used to determine these percentiles, to more accurately reflect the distribution of actual prices that the hospital has received for an item or service. CMS also proposes to require hospitals to attest that they have included all applicable payer-specific negotiated charges in 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 the dollar amount, and included the name of the hospital's chief executive officer, president or senior official designated to oversee the encoding of true,

accurate, and complete data. Lastly, CMS proposes to reduce the amount of civil monetary penalty for a noncompliance with the HPT requirements by 35 percent when a hospital agrees with CMS' determination of their noncompliance and waives the right to a hearing by an Administrative Law Judge.

- **Graduate Medical Accreditation:** CMS is proposing that accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place, diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of Federal law. CMS also notes that the Secretary may certify other organizations as accreditors to increase the potential for competition in the accreditation space and improve the quality of the accreditation process.