DeBrunner & Associates

21351 Gentry Dr., Ste. 210 • Sterling, VA 20166 • Phone: 703-444-4091 • Fax: 703-444-3029 • www.debrunner.us

Memorandum

To:

From: Ellen Kugler and Kate Finkelstein

Date: July 16, 2025

Subject: Proposed CY 2026 Medicare outpatient prospective payment system and physician fee schedule regulations

---

Over the past 48 hours the Centers for Medicare & Medicaid Services (CMS) has published proposed versions of two of its most important Medicare payment regulations: the CY 2026 Medicare outpatient prospective and ambulatory surgical center payment systems regulation and the physician fee schedule regulation. The following are summaries of the two regulations, with some of the language taken directly from CMS documents.

The Proposed Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System Regulation

Outpatient Rates and Expedited Repayment for Non-Drug Services

CMS proposes raising outpatient rates a net 2.4 percent, a 3.2 percent market basket update minus a 0.8 percentage point productivity cut.

Offsetting most of this proposed increase, however, CMS also proposes accelerating the clawback related to a past legal decision about the manner in which Medicare reimburses eligible providers for 340B-covered drugs. The so-called 340B final remedy rule called for offsetting outpatient payments 0.5 percentage points a year until past overpayments have been recovered, which was estimated to occur in CY 2041. In the proposed rule, however, CMS calls for accelerating this clawback and reducing outpatient payments to providers subject to the clawback by two percentage points a year for the next six years starting in CY 2026, meaning that the proposed 2.4 percent rate increase would actually be an increase of only 0.4 percent for hospitals subject to the 340B remedy.

A Proposed New Site-Neutral Payment Policy

CMS proposes a site-neutral payment policy for the outpatient administration of drugs. Under this proposal it would pay 40 percent of the outpatient prospective payment system rate for administering drugs in excepted off-campus provider-based departments. CMS believes it has authority under current statute to implement site-neutral payments as a means of controlling unnecessary increases in the volume of covered outpatient services and that a 2020 decision by the U.S. Court of Appeals for the D.C. Circuit affirmed that authority. Rural sole community hospitals would be excepted from this payment policy. CMS requests comments on whether it should expand site-neutral policies to clinic visits in on-campus outpatient departments and whether to develop a systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity.

Eliminating the Inpatient Only List

CMS proposes phasing out the inpatient only (IPO) list over a three-year period, beginning with removing 285 mostly musculoskeletal procedures for CY 2026. This proposal would allow for these services to be paid by Medicare in the hospital outpatient setting when determined to be clinically appropriate. When CMS addressed the inpatient only list in 2021 it established a policy in which procedures removed from that list beginning in 2021 would be exempted from certain medical review activities related to the two-midnight policy. CMS proposes continuing this exemption for CY 2026 and subsequent years until it determines that the service or procedure is more commonly performed in the Medicare population in an outpatient setting.

Ambulatory Surgical Center Covered Procedures List

CMS proposes revising the ambulatory surgical center covered procedures list criteria to modify the general standard criteria and eliminate five of the general exclusion criteria. As a result of these criteria changes, CMS proposes adding 276 procedures to the ambulatory surgical center-covered procedures list and adding 271 codes to that list for removal from the inpatient only list for CY 2026.

Market-Based MS-DRG Relative Weight Data Collection and Methodology Proposal

CMS proposes collecting from hospitals the median payer-specific charges they have negotiated with Medicare Advantage organizations and disclosed under CMS's hospital price transparency rules and then using this data to help determine MS-DRG relative weights for inpatient hospital services beginning in FY 2029. CMS also is seeking comment on how market-based approaches such as this one could be used to improve additional Medicare fee-for-service payment systems.

Ambulatory Surgical Center Market Basket Update

CMS proposes raising ambulatory surgical center rates a net 2.4 percent, which consists of a 3.2 percent market basket update minus a 0.8 percentage point productivity cut.

Hospital Price Transparency

CMS proposes several modifications to current hospital price transparency requirements. Beginning on January 1, 2026, hospitals would be required to:

- Disclose the tenth, median, and ninetieth percentile allowed amounts in machine-readable files when payer-specific negotiated charges are based on percentages or algorithms and the count of allowed amounts used to determine these percentiles and comply with specific instructions regarding the methodology, including the lookback period, that must be used to calculate the tenth, median, and ninetieth percentile allowed amounts.
- 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, that the hospital has provided in the machine readable format all necessary information available to the hospital for the public to be able to derive the dollar amount, and include the name of the hospital's chief executive officer, president, or senior official designated to oversee the encoding of true, accurate, and complete data.
- Encode their organizational national provider identifiers in their machine-readable format.
- Reduce the amount of civil monetary penalty for noncompliance with transparency requirements by 35 percent when they agree with CMS's determination of their noncompliance and waive the right to a hearing before an administrative law judge.

Hospital Quality Reporting Program

CMS proposes adopting the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) 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.

It proposes extending the voluntary reporting for the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults eCQM, beginning with the CY 2027 reporting period.

CMS proposes updating the Hospital Outpatient Quality Reporting Program's Extraordinary Circumstances Exception Policy to explicitly include extensions as a type of extraordinary circumstances relief option, in addition to exceptions.

And CMS proposes removing the following quality measures:

- The COVID–19 Vaccination Coverage Among Healthcare Personnel measure beginning with the CY 2024 reporting period/CY 2026 payment determination.
- The Hospital Commitment to Health Equity measure beginning with the CY 2025 reporting period/CY 2027 payment determination.
- The Screening for Social Drivers of Health (SDOH) measure beginning with the CY 2025 reporting period.
- The Screen Positive Rate for SDOH measure beginning with the CY 2025 reporting period.
- The Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure.
- The Left Without Being Seen measure, beginning with the CY 2028 reporting period/CY 2030 payment determination, contingent on the Emergency Care Access & Timeliness eCQM being finalized as proposed.

Rural Emergency Hospital Quality Reporting Program

CMS proposes adopting the Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination as an optional measure – specifically, as an alternative to reporting the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure. CMS also is establishing related eCQM data submission and reporting requirements beginning with the CY 2027 reporting period/CY 2029 program determination.

CMS proposes removing the Hospital Commitment to Health Equity measure beginning with the CY 2025 reporting period/CY 2027 program determination; the Screening for SDOH measure beginning with the CY 2025 reporting period; and the Screen Positive Rate for SDOH measure beginning with the CY 2025 reporting period.

Finally, CMS proposes updating the Hospital Rural Emergency Hospital Quality Reporting Program's Extraordinary Circumstances Exceptions Policy to explicitly include extensions as a type of extraordinary circumstances relief option, in addition to exceptions.

Ambulatory Surgical Center Quality Reporting Program

CMS proposes adopting the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) with voluntary reporting beginning with the CY 2027 reporting period followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination. CMS also proposes that ambulatory surgical centers must use the Hospital Quality Reporting system for data submission of PRO–PMs generally, including the proposed Information Transfer PRO–PM.

CMS proposes removing the COVID–19 Vaccination Coverage Among Healthcare Personnel measure beginning with the CY 2024 reporting period/CY 2026 payment determination; the Facility Commitment to Health Equity measure beginning with the CY 2025 reporting period/CY 2027 payment determination; the Screening for SDOH measure beginning with the CY 2025 reporting period; and the Screen Positive Rate for SDOH measure beginning with the CY 2025 reporting period.

Finally, CMS proposes updating the Ambulatory Surgical Center Quality Reporting Program's Extraordinary Circumstances Exceptions Policy to explicitly include extensions as a type of extraordinary circumstances relief option, in addition to exceptions.

Request for Information for the Hospital Outpatient, Rural Emergency Hospital, and Ambulatory Surgical Center Quality Reporting Programs

In this year's proposed rule CMS seeks public input on future measure concepts related to well-being and nutrition – specifically, tools and measures that assess overall health, happiness, and life satisfaction that could include aspects of emotional well-being, social connections, purpose, and fulfillment. CMS also seeks public input on tools and frameworks that promote healthy eating habits, exercise, nutrition, or physical activity.

Hospital Quality Star Rating Modifications

CMS proposes updating its methodology for calculating hospitals' Overall Hospital Quality Star Rating to emphasize safety of care. After seeking input in last year's proposed rule, CMS now proposes a two-stage update of its methodology.

In stage 1, CMS proposes implementing a 4-star cap for hospitals in the lowest quartile of the Safety of Care measure group performance in CY 2026. CMS proposes limiting hospitals in the lowest quartile (lowest-performing 25 percent of the Safety of Care measure group based on at least three measure scores) to a maximum of 4 stars out of 5.

In stage 2, CMS proposes implementing a blanket 1-star reduction for hospitals in the lowest quartile of Safety of Care measure group performance beginning in CY 2027. It proposes reducing the Overall Hospital Quality Star Rating of any hospital in the lowest quartile of the Safety of Care measure group by 1 star, to a minimum 1-star rating.

This methodology update will apply a blanket reduction of one star to any hospital initially assigned a 2-, 3-, 4- or 5-star rating. The stage 1 methodology update will be used to calculate the Overall Hospital Star Rating in 2026 while the Stage 2 methodology update will be used to permanently calculate the Overall Hospital Star Rating beginning in 2027 and later years. The Stage 2 methodology update is intended to replace the Stage 1 methodology update, not to supplement it.

Intensive Outpatient Programs

CMS proposes updating Medicare rates for intensive outpatient program (IOP) services furnished in hospital outpatient departments and community mental health centers. It proposes maintaining the existing rate structure, with two IOP APCs for each provider type: one for days with three services per day and one for days with four or more services per day. CMS proposes using CY 2024 claims data and the latest available cost information from cost reports beginning three fiscal years prior to the year that is the subject of the rulemaking.

For CY 2026, CMS proposes maintaining the calculation of hospital-based IOP rates for three services per day and four or more services per day based on cost per day using outpatient prospective payment system data that includes IOP or partial hospitalization program (PHP) and non-IOP or PHP days. CMS believes continuing to use the outpatient prospective payment system data set will enable it to capture data from hospital claims that are not identified as IOP or PHP but that include the service codes and intensity required for an IOP or PHP day.

CMS proposes changing its methodology for calculating community mental health center IOP costs for three services per day and four or more services per day. Specifically, it proposes calculating community mental health center costs based on 40 percent of the proposed hospital-based IOP costs.

Partial Hospitalization Programs

CMS proposes updating Medicare rates for PHP services furnished in hospital outpatient departments and community mental health centers. It proposes maintaining the existing rate structure, with two PHP APCs for each provider type: one for days with three services per day and one for days with four or more services per day. Consistent with the outpatient prospective payment system, CMS proposes using CY 2024 claims data and the latest available cost information from cost reports beginning three fiscal years prior to the year that is the subject of the rulemaking.

For CY 2026, CMS proposes maintaining the calculation of hospital-based PHP rates for three services per day and four or more services per day based on cost per day using outpatient prospective payment system data that includes IOP or PHP and non-IOP or PHP days.

CMS proposes changing the methodology for calculating community mental health center PHP costs for three services per day and four or more services per day. Specifically, it proposes calculating the community mental health center costs based on 40 percent of the proposed hospital-based PHP costs. This change would stabilize rates for community mental health centers by basing them on data from a much larger set of providers while preserving the adjustment for the structural differences between community mental health centers and hospital costs.

Access to Non-Opioid Treatments for Pain Relief

CMS proposes continuing policies to provide temporary additional payments for certain non-opioid treatments for pain relief in hospital outpatient departments and ambulatory surgical centers from January 1, 2025 through December 31, 2027. Specifically, it proposes five drugs and six devices to qualify as non-opioid treatments for pain relief, with these products to be paid separately for both hospital outpatient departments and ambulatory surgical centers starting in CY 2026. CMS is soliciting comment and supporting documentation from interested parties on additional products that may qualify for separate payment under this provision for CY 2026.

Skin Substitutes

Since CY 2014, CMS has unconditionally packaged skin substitute products furnished in the outpatient hospital setting into their associated application procedures as part of a broader policy to package all drugs and biologicals that function as supplies when used in a surgical procedure. The agency currently divides the skin substitutes into high-cost group and low-cost groups to ensure adequate resource homogeneity among APC assignments for skin substitute application procedures. This payment approach differs from the payment policy for skin substitutes furnished in the non-facility setting, where skin substitute products are paid under the ASP plus six percent payment methodology.

For CY 2026, CMS proposes unpackaging skin substitute products from the application services and establishing several APCs based on relevant product characteristics rather than based on stated prices for provision of these products when they are used during a covered application procedure paid under the outpatient prospective payment system (CPT codes 15271-15278). CMS also is proposing to align skin substitute categorization consistent with their FDA regulatory status, such as 361 Human Cells, Tissues, and Cellular and Tissue-Based Products, and the device types: Pre-Market Approvals and 510(k)s.

For CY 2026 CMS proposes using a single rate for these three categories of skin substitute products to ensure that it is not underestimating the resources involved with furnishing these services. In future years it intends to propose rates that differentiate between the three FDA regulatory categories. CMS is proposing to implement these policy changes in both the hospital outpatient department and physician office settings to remain consistent across different settings of care. The proposed payment policy for skin substitutes in the physician office setting is described below, in the portion of this memo summarizing the proposed physician fee schedule regulation.

Graduate Medical Education Accreditation

CMS proposes that graduate medical education (GME) 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 accreditation and improve the quality of the accreditation process.

Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare

CMS continues to seek public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

Final Notes on the Proposed Hospital Outpatient Prospective Payment System Regulation

All of the proposed changes described above are presented in much greater detail in various CMS documents, including the 913-page preview version. Those resources include:

- the preview version of the proposed rule
- this CMS fact sheet
- this CMS news release

The deadline for interested parties to submit written comments in response to the proposed rule is 60 days after its official publication in the *Federal Register*, which is scheduled for tomorrow.

The Proposed Medicare Proposed Physician Fee Schedule Regulation

Physician Fees

CMS proposes using two separate conversion factors as required by statute: one for qualifying alternative payment model (APM) participants and one for physicians and practitioners who are not qualifying participants. This calculation also includes the one-year 2.5 percent update provided for in the recently enacted OBBA. The proposed CY 2026 qualifying APM conversion factor of $33.59 represents a projected increase of $1.24 (+3.83 percent) from the current conversion factor of $32.35 and the proposed CY 2026 non-qualifying APM conversion factor of $33.42 represents a projected increase of $1.17 (+3.62 percent) from the current conversion factor of $32.35.

CMS also proposes applying an efficiency adjustment – the Medicare Economic Index productivity adjustment – to the work RVU and corresponding intraservice portion of physician time of non-time-based services that it expects to experience gains in efficiency over time; such adjustments will be payment reductions. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of medical management.

CMS also proposes updating its physician practice expense methodology to better reflect the relative relationship between the cost of services in a facility versus non-facility setting, the geographic practice cost indices, and malpractice RVUs. This issue is also addressed in this year's proposed outpatient prospective payment system regulation, which is summarized

separately in this memo. The agency will continue its work with the American Medical Association (AMA), the RAND Corporation, and interested stakeholders to analyze and develop alternative methods for measuring physician practice expenses and related inputs. CMS notes that it has received the AMA's physician practice information and clinician practice information surveys that were discussed as potential new data sources in prior rulemaking but is not proposing to replace the current practice expense data for CY 2026 rate-setting.

Telehealth

The proposed regulation calls for several changes in the use of telehealth. CMS proposes streamlining the process for adding services to the Medicare telehealth services list; permanently removing frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations, which had been waived since the public health emergency; and permanently adopting a definition of direct supervision that permits physicians or supervising practitioners to provide such supervision through real-time audio and visual interactive telecommunications. It does not propose extending beyond December 31, 2025 its current policy of permitting teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings. Instead, it proposes transitioning to its pre-COVID policy requiring that for services provided within Metropolitan Statistical Areas, teaching physicians must maintain physical presence during critical portions of resident-furnished services to qualify for Medicare payment. The proposed rule also calls for maintaining the rural exception established in the CY 2021 physician fee schedule final rule.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

CMS proposes creating optional add-on codes for advanced primary care management services that would facilitate providing complementary behavioral health integration or psychiatric Collaborative Care Model (CoCM) services. It proposes establishing three new G-codes to be billed as add-on services when the advanced primary care management base code is reported by the same practitioner in the same month. The services associated with the proposed add-on codes are meant to be directly comparable to existing CoCM and behavioral health integration codes. CMS also seeks comments on how it should consider the application of cost sharing for advanced primary care management services, especially if the agency includes preventive services in the advanced primary care management bundles.

To support access to digital mental health treatment devices furnished incident to professional behavioral health services, CMS proposes expanding its payment policies for digital mental health treatment services to also make payment for devices used in the treatment of attention deficit hyperactivity disorder (ADHD). It requests feedback about establishing coding and payment policies for other digital therapy devices classified under other FDA regulations and comments on the possibility of establishing additional separate coding and payment for a broader-based set of services describing digital tools used by practitioners intended as complements to mental health treatment plans of care.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes adopting the optional add-on codes described above for advanced primary care management services that would facilitate billing for behavioral health integration and Psychiatric Collaborative Care Model (CoCM) services when rural health centers (RHCs) and federally qualified health centers (FQHCs) provide advanced primary care. It also proposes requiring RHCs and FQHCs to report individual codes that make up both the CoCM and the Communications Technology-Based Services (CTBS) and Remote Evaluation Services' HCPCS codes G0512 and G0071, respectively. In addition, it proposes adopting services that are established and paid under the physician fee schedule and designated as care management services and care coordination services for purposes of separate payment for RHCs and FQHCs.

In addition, it proposes permanent adoption of a definition of direct supervision that permits physicians supervising practitioners to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only) for RHC and FQHC services and supplies requiring direct supervision. CMS also proposes policies for non-behavioral health telehealth visits that enable RHCs and FQHCs to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on such claims, including for services furnished using audio-only communications technology through December 31, 2026.

New Mandatory Ambulatory Care Model

CMS proposes introducing a new Ambulatory Specialty Model (ASM), a mandatory payment model focused on specialty care for beneficiaries with heart failure and low back pain. The model seeks to enhance the quality of care and reduce low-value care by improving chronic disease management. The model would reward specialists who detect signs of worsening chronic conditions early, enhance patients' function, reduce avoidable hospitalizations, and use technology that enables them to communicate and share data electronically with patients and their primary care providers.

CMS will select a stratified random sampling of approximately 25 percent of Core Based Statistical Areas (CBSAs) and metropolitan divisions to participate in the model. Participating specialists include those that have served at least 20 Medicare fee-for-service patients with heart failure or low back pain in the previous year. Eligible heart failure specialists will include only cardiologists. Eligible low back pain specialties include anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation. Specialists that are mandated to participate in the model would be subject to payment adjustments that range from -0.9 percent to +0.9 percent. The model would launch in January 2027 and run for five performance years, through December of 2031.

Existing Care Models

CMS is proposing a number of changes in its Medicare Shared Savings program. Among them:

- Reducing the length of time an accountable care organization (ACO) may participate in a one-sided model of the BASIC track to a maximum of five performance years, during the ACO's first agreement period in the BASIC track's glide path instead of the current seven performance years.
- Modifying the eligibility and financial reconciliation requirements that ACOs have at least 5000 assigned Medicare fee-for-service beneficiaries.
- Changing quality performance standards and other quality reporting requirements, including removing the health equity adjustment.
- Revising the definition of a beneficiary eligible for Medicare Clinical Quality Measures (Medicare CQMs) for ACOs participating in the Shared Savings Program so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO.
- Updating the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set for Shared Savings Program ACOs, including to remove Quality ID: 487 Screening for Social Drivers of Health and expanding the survey modes for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey from a mail-phone administration protocol to a web-mail-phone administration protocol beginning with performance year 2027.
- Expanding application of the Shared Savings Program quality and finance extreme and uncontrollable circumstances policies to include cyberattacks.

Skin Substitutes

Currently, Medicare pays for most skin substitutes as if they were biologicals under the average sales price (ASP)-based payment methodology. Now, CMS proposes paying for skin substitute products as incident-to supplies when they are used as part of a covered application procedure paid under the physician fee schedule in a non-facility setting or under the outpatient prospective payment system in a hospital outpatient department setting. CMS also proposes aligning skin substitute categorization with their FDA regulatory status, such as 361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) and device types.

Prevention and Wellness

CMS proposes several initiatives that seek to foster prevention and wellness. It proposes a change in the Medicare Diabetes Prevention Program to give more people with Medicare access to coaching, peer support, and practical training in dietary change, physical activity, and behavior change strategies to delay or prevent the onset of Type 2 diabetes for people with prediabetes at no cost to the beneficiary. The agency also proposes removing ten quality measures that it believes did not directly improve patient health outcomes and adding five new outcome measures that focus on the prevention of chronic disease, including prescreening for diabetes. The proposed rule includes a request for information seeking recommendations on improving wellness, prevention, and chronic disease management, including input on nutrition counseling and physical activity.

Requests for Information

In addition to the requests for information noted above, the proposed rule seeks information about:

- Improving the accuracy of payment for global surgical packages – specifically, comment about procedure shares and what the procedure shares should be based on when the transfer of care modifier(s) are applied for the 90-day global packages. CMS also seeks comment and stakeholder input on current practice standards and division of work between surgeons and providers of post-operative care.
- Approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program.

Final Notes on the Proposed Physician Fee Schedule Regulation

To learn more about the proposed regulation, see the following resources:

- a CMS news release
- a CMS fact sheet about the proposed rule in general
- a fact sheet on the CY 2026 Quality Payment Program proposed changes
- a fact sheet on the proposed Medicare Shared Savings Program changes in the proposed rule
- additional information about the Ambulatory Specialty Model
- the full proposed rule

The deadline for stakeholders to submit comments is September 12.

Please let us know if you have any questions.