Key Provisions in Medicare's 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule [CMS-1834-FC]

CMS PROPOSAL	ASCA COMMENTS	FINAL RULE
Updating the ASC Conversion Factor (Starts on page 617 of 913) • CMS proposes to update the ASC conversion factor using the hospital market basket (HMB) (together with the multi-factor productivity (MPF) adjustment) through 2026. ***The initial five-year trial was 2019-2023, and was then extended two years, through 2025. CMS is now proposing to extend the trial one more year.*** • **Migration Data:** CMS reiterated its intent to assess whether there is a migration of the performance of procedures from the hospital setting to the ASC setting because of the use of a hospital market basket update, as well as whether there are any unintended consequences, such as less than expected migration of the performance of procedures from the hospital to the ASC setting. • For CY 2026, the conversion factor is proposed to be increased by 2.4 percent under the OPPS and ASC Payment System (for facilities that meet the quality reporting requirements) (calculated as 3.2 percent HMB update minus the MFP of 0.8 percent). The proposed conversion factor is **$56.207** for ASCs and **$91.747** for HOPDs. While the conversion factor is an increase from that in the 2025 final rule ($53.514), the ratio of these conversion factors is 61.26 percent, which is slightly lower than the ratio in 2025 (61.56 percent).	• ASCA thanked CMS for listening to our request to continue to use the HMB to update ASC reimbursement rates but discussed inflation and the increasing costs that far exceed the HMB. We highlighted increased costs for our facilities, including trends regarding anesthesia stipends and staffing costs.	**(Starts on page 1158 of 1657 in final rule)** • CMS finalized its proposal to continue to update the ASC conversion factor using the HMB through 2026. • For CY 2024, the conversion factor is increased by 2.6 percent under the OPPS and ASC Payment System (for facilities that meet the quality reporting requirements) (calculated as 3.3 percent HMB update minus the MFP of 0.7 percent). • Based on this final update, CMS estimates that total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2026 will be approximately $9.2 billion, an increase of approximately $450 million compared to estimated CY 2025 Medicare payments. • For HOPDs, CMS estimates total payments will be approximately $101 billion, an increase of $8 billion compared to estimated CY 2025 Medicare payments. The final conversion factor is **$56.322** for ASCs (up from proposed) and **$91.415** for HOPDs (down from proposed). The ratio of these conversion factors is 61.61 percent, which is higher than the proposed ratio, and the ratio in the 2025 final rule (61.56 percent).

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Updating the ASC Relative Payment Weights for CY 2026 (Starts on page 613 of 913) • CMS proposes an ASC weight scalar of 0.842, which is a decrease from the 2025 final weight scalar of 0.872. • The OPPS weight scalar is proposed to be 1.4624 • Impact of 340B remedy offset on ASC weights: "As discussed in sections V.B.8.i. and XIII.C.4. of this proposed rule, we propose that the OPPS payment rates used for rate setting under the ASC payment system for CY 2026 and subsequent years would not incorporate the two percent prospective offset to the OPPS conversion factor, as a result of the 340B remedy offset that we are proposing to implement in this proposed rule."	• ASCA requested that CMS discontinue use of the ASC weight scalar, as continuing the scalar is counter to the Agency's stated interests in moving volume to the ASC. • We highlighted cost savings research and provided analysis showing shifting volume to the ASC setting will save Medicare money.	**(Starts on page 1150 of 1657)** • CMS finalized an ASC weight scalar of 0.872, indicating that the 0.842 in the proposed rule had been an error. • CMS disagrees with ASCA (and other commenters) requesting that CMS discontinue use of the ASC weight scalar. • The OPPS final weight scalar is 1.4879, an increase from the proposed weight scalar of 1.4624, and a significant increase of the 2025 HOPD weight scalar of 1.4452.
Proposed Additions to the List of ASC Covered Surgical Procedures (Starts on page 562 of 913) • CMS proposes to add 276 codes to the ASC-CPL that are currently payable in the HOPD setting by revising the criteria under §416.166 to modify the general standard criteria and to eliminate five of the general exclusion criteria, moving them into a new section as nonbinding physician considerations for patient safety. • CMS is also proposing to add 271 of the codes slated to be removed from the inpatient-only list (IPO list) to the ASC-CPL in 2026.	• ASCA supported the changes proposed for the ASC covered procedures list (ASC-CPL) and encouraged further policy changes to ensure that the appropriate site of care is determined by healthcare providers. • ASCA requested that CMS remove the restriction that prohibits ASCs from billing Medicare for unlisted codes. • While we were happy to see many of the codes requested proposed for addition to the ASC-CPL, we asked	**(Starts on page 1053 of 1657)** • CMS finalized its proposal to expand the ASC-CPL by revising the criteria under §416.166 to modify the general standard criteria and to eliminate five of the general exclusion criteria, moving them into a new section as nonbinding physician considerations for patient safety. • Based on these criteria changes, CMS will add 289 procedures to the ASC-CPL, including all 276 proposed and 13 additional codes requested by commenters. • One of those additional codes as the cardioversion code (92960) requested by ASCA.

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• These lists of codes proposed for addition to the ASC-CPL in 2026 can be found in Table 80 and Table 81, starting on page 569 in **the rule**. • Of the codes ASCA recommended through the Pre-Proposed Rule Recommendation Request, CMS proposes to add: • **Cardiovascular Codes** -Electrophysiology Studies and Ablations: 93650, 93653, 93654 and 93656 -Percutaneous Coronary Intervention (PCI): C9602, C9604 and C9607 • **Spine Codes** -Posterior Lumbar Interbody Fusion: 22630 -Combined Posterior Lumbar and Posterior Lumbar Interbody Fusion: 22633 • **Vascular Code** -Vascular Embolization or Occlusion: 37244 • ASCA had also requested additional cardioversion and transesophageal echocardiogram codes (92960, 93312 and 93318) and electrophysiology studies and ablation codes (93619, 93620, 93624, 93642 and 93724) which CMS did not propose for addition.	that our other requested codes be finalized for addition as well: - Electrophysiology Studies and Ablations: 93619, 93620, and 93642 - Cardioversion and Transesophageal Echocardiogram (TEE): 92960, 93312 and 93318	
Proposed Elimination of the Inpatient-Only List (IPO-list) (Starts on page 453 of 913) • For CY 2026 and subsequent years, CMS proposes to eliminate the IPO list through a 3-year transition, completing the elimination by January 1, 2029.	• ASCA supported CMS allowing discretion to clinical decision-making. However, there might be certain unintended consequences of removing the IPO list entirely.	**(Starts on page 1064 of 1657)** • CMS finalized its proposal to start the transition of eliminating the IPO list over the next few years. CMS will add 271 of the codes it is removing from the IPO list in 2026 to the ASC-CPL, for a total of 560

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• For CY 2026, CMS proposes that musculoskeletal services be the first group of services removed from the IPO list.	• The complete elimination of the IPO list means that every code must be assigned to an ambulatory payment classification (APC) group, regardless of whether there will be any volume in the outpatient setting. ASCA is concerned that even projecting a small amount of volume for procedures that will not actually be performed in our setting will negatively impact procedures currently on the ASC-CPL.	codes finalized for addition to the ASC-CPL in 2026. • The lists of codes finalized for addition to the ASC-CPL in 2026 can be found in Table 131 and Table 132, starting on page 1,068 in the rule.
Proposed Payment for ASC Add-On Procedures Eligible for Complexity Adjustments under the OPPS (Starts on page 541 of 913) • In 2023, CMS finalized a policy to provide increased payment to ASCs for combinations of certain service codes and add-on procedure codes that are eligible for a complexity adjustment under the OPPS because while add-on codes (N1) do not come with additional reimbursement (packaged into primary code), the addition of the add-on codes to a primary procedure code often changes the complexity of the procedure, making it more costly to perform. • For 2026, CMS identified **42** different complexity adjustment code combinations for codes that are payable in the ASC setting and would be eligible for	• ASCA supports further evaluation of the complexity adjustment policy to ensure all appropriate code combinations are contemplated. • We raised concerns that the volume of cases with the N1 payment indicator are not being captured. • We understand that claims may be denied by Medicare Administrative Contractors (MAC) when N1 codes appear with the primary code, even though the primary code is payable. CMS must clarify in the billing claims processing manual that the entire claim will not be denied by	• CMS finalized **46** complexity adjusted code combinations, up from 42 in the proposed rule and 45 in 2025. • These codes can be found here: https://www.cms.gov/license/ama?file=/files/zip/2026-final-asc-cpx-supplemental-file.zip

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a complexity adjustment if the procedure were performed in an HOPD. This is down from 45 in 2025, 47 in 2024 and 55 in 2023.	the MACs when an add-on code is billed that may not be deemed payable.	
Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs (623 of 913) • **CMS proposes to remove:** (1) the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the Hospital OQR and ASCQR Program measure sets beginning with the CY 2024 reporting period/CY 2026 payment determination; ***(ASC-20* in the ASCQR Program)**; (2) the Hospital Commitment to Health Equity (HCHE) measure from the Hospital OQR and REHQR Program measure sets and the Facility Commitment to Health Equity (FCHE) measure from the ASCQR Program measure set beginning with the CY 2025 reporting period/CY 2027 payment or program determination (***ASC-24* in the ASCQR Program)**; and (3) the Screening for Social Drivers of Health (SDOH) measure and the Screen Positive Rate for SDOH measure from the Hospital OQR, REHQR, and ASCQR Program measure sets beginning with	• ASCA supported the removal of these four measures from the ASCQR Program. • We echoed many of the ASC Quality Collaboration's comments and concerns.	**(Starts on page 1282 of 1657)** CMS finalized its proposal to remove the following measures: • *ASC-20: COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)* beginning with the CY 2024 reporting period/CY 2026 payment determination • *ASC-22: Screening for Social Drivers of Health (SDOH)* and *ASC-23: Screen Positive Rate for SDOH*, which were previously finalized to be mandatory with CY 2026 data collection/CY 2028 payment determinations • *ASC-24: Facility Commitment to Health Equity*, which was previously finalized to be mandatory with CY 2025 reporting period/CY 2027 payment determination

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the CY 2025 reporting period **(*ASC-22 and ASC-23,* respectively, in the ASCQR Program*)***. • Additionally, CMS seeks comments regarding measured concepts related to well-being and nutrition for future consideration in the Hospital OQR, REHQR, and ASCQR Programs. • CMS also proposes to update and codify the Extraordinary Circumstance Exception (ECE) policy to clarify that CMS has the discretion to grant an extension in response to an ECE request for the Hospital OQR, REHQR, and ASCQR Programs.		
Proposed Changes to the ASCQR Program Measure Set (Starting on page 683 of 913) • CMS proposes to adopt 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) beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination. This measure has not been tested in the ASC setting.	• ASCA did not support the addition of the Information Transfer PRO–PM measure to the ASC Quality Reporting Program. • We raised concerns that this survey lacks sufficient clinical support and that the burden will far outweigh any perceived benefits. • We mentioned low response rates and survey fatigue occurring with OAS CAHPS.	**(Starts on page 1290 of 1657)** • CMS decided **not** to finalize the adoption of 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) at this time. • CMS cited survey fatigue as a reason for refusing to finalize.