



Medicare OPPS Final Rule Impact Analysis

Calendar Year 2026 | Version 1

Analysis Description

The calendar year (CY) 2026 Medicare Outpatient Prospective Payment System (OPPS) Final Rule Analysis is intended to show providers how Medicare outpatient fee-for-service (FFS) payments will change from CY 2025 to CY 2026 based on the policies set forth in the CY 2026 OPPS final rule.

CY 2026 OPPS Final Rule Changes Modeled in This Analysis:

- Market Basket Update: 3.3% market basket increase to the outpatient rate.
- ACA-Mandated Market Basket Adjustment: -0.7 percentage point productivity adjustment to the market basket authorized by the Affordable Care Act (ACA) of 2010.
- 340B Remedy Offset: -0.49% adjustment to the rate to recoup payments made under the 340B drug payment reduction policy during CYs 2018–2022.
- Budget Neutrality Adjustments: Reflects the impact of adjustments to the rate based on changes to the wage index (-0.10%), 5% stop loss and transition wage index (-0.05%), cancer hospital payments (+0.00%), as well as pass-through spending/outlier payments (+0.07%), and other budget neutrality in order to maintain program budget neutrality. CMS did not provide individual budget neutrality factors for wage index budget neutrality due to wage data changes and the budget neutrality factor to offset the bottom quartile increase of wage indexes for CY 2025. Therefore, the removal of the CY 2025 low wage index policy budget neutrality adjustment is included in this line.
- Wage Index (Removal of Previous Low Wage Index and 5% Stop Loss Adjustments): Removal of the previous bottom quartile and stop loss adjustments, resulting in a CY 2025 wage index value that includes adjustments for the rural floor.
- Wage Index (Removal of Previous Rural Floor Budget Neutrality): Removal of the previous rural floor budget neutrality from the previous year wage index.
- Wage Index (Removal of Previous Rural Floor Wage Index): Removal of the rural floor from the previous year wage index, resulting in a wage index with no adjustments.
- Wage Index (Change due to Wage Index and Labor Share prior to rural floor): Updated wage index values based on the federal fiscal year (FFY) 2026 Inpatient PPS (IPPS) final rule hospital wage indexes compared to the FFY 2025 IPPS final rule correction notice (CN) hospital wage indexes, including the impact of new wage data, reclassifications, rural and legislated floors, and other adjustments to the wage indexes. This value does not include the CMS increase to the wage index of hospitals eligible for the 5% wage index stop loss, the wage index transition, nor the rural floor adjustments.

- Wage Index (Current Rural Floor Wage Index Added): The current year wage index with the addition of the rural floor adjustments. This budget neutrality is from the FFY 2026 IPPS final rule and is applied directly to the wage index.
- Wage Index (Current Rural Floor Budget Neutrality Added): The current year wage index with the addition of the rural floor budget neutrality.
- Wage Index (5% Stop Loss): 5% stop loss cap for hospitals whose CY 2026 wage index that was less than 95% of what it was for CY 2025. This also includes the transitional, budget-neutral wage index stop loss for providers who were eligible for the low wage index policy in FFY 2024 and whose FFY 2026 wage index is less than 90.25% of their FFY 2024 wage index.
- Ambulatory Payment Classification (APC) Factor/Updates: This impact represents the changes to the APC assignments and weights finalized for CY 2026. It is inclusive of CMS' policies regarding the creation of comprehensive APCs, the expansion of the categories of items/services that are packaged into APCs for payment as opposed to separately paid, and the anticipated change in outlier payments. This impact is derived by attributing all remaining payment changes to this category (after impact for wage index, market basket, etc.).
- Change in Rural Adjustment: Payment changes due to the change in the rural status of provider.
- Site Neutral Off-Campus Provider Based Department Drug Administration (SN Provider Based Department (PBD) Drug Admin) Adjustment: Reflects the estimated impact of setting OPSS payments for drug administration services provided at off-campus PBDs equivalent to the Medicare Physician Fee Schedule site-neutral payment rate, reducing the OPSS payment amount by 60%, in a non-budget-neutral manner. This reduction does not apply to payments made to rural sole-community hospitals.

The impacts in the analysis do not include the impact of the sequestration reduction to all lines of Medicare payment authorized by Congress to end in FFY 2032. The impact of the sequester applicable to OPSS-specific payment has been calculated separately and is provided below the impact table.

The second tab of the report lists a hospital's highest (up to 25) Medicare FFS APCs, ranked by difference from year to year in unadjusted payment impacts. Payments are not calculated for procedures that CMS did not provide a payment for in the standard analytic file (SAF). In addition, payments for subsequent surgical procedures on the same claim have been discounted. However, volumes are inclusive of all procedures performed, regardless of payment. Therefore, volumes multiplied by wage index adjusted APC amounts may not always equal total payments.

Data Sources

Except where otherwise mentioned, hospital characteristics, outpatient procedure volumes, and estimated CYs 2025 and 2026 outpatient revenues are from the CY 2026 OPSS final rule Impact File, which utilizes CY 2024 outpatient claims data. OPSS conversion factors are from the CY 2025 final rule and the CY 2026 final rule. Wage indexes are based on the wage index tables from the FFYs 2025 IPPS final rule CN and 2026 IPPS final rule.

The impact of CMS' wage index policies is calculated using the FFY 2025 IPPS final rule CN and FFY 2026 IPPS final rule wage index tables.

Data for the top APCs are from the CY 2024 Medicare FFS 100% Outpatient SAF. APC weights are from Addendum A of the CYs 2025 and 2026 OPSS final rule, while payments are wage index adjusted when appropriate and include copayments. When an APC does not have a relative weight, the payment rate from the CY 2025 OPSS

final rule or CY 2026 OPPS final rule Addendum A is used instead, as applicable. Hospital characteristics are from the CYs 2025 and 2026 OPPS final rule impact files. APCs and descriptions are from the CY 2026 OPPS final rule Addendum B. APC amounts may not always equal total payments. APCs with case counts less than 11 have been removed due to CMS' privacy rules.

Impacts for providers subject to the 340B remedy offset are based on those listed in Addendum R of the CY 2026 OPPS final rule.

The SN PBD Drug Admin adjustment is based on the CY 2024 Outpatient SAF. Revenues exclude those received through sources outside the OPPS and are used to determine an estimated impact of this policy, based on a subset of OPPS services with modifier "PO" belonging to the applicable drug administration APCs in Addendum A of the CY 2025 OPPS final rule (APCs 5691–5694).

This analysis was developed to measure the impact of OPPS policy changes only. Hospital volume and patient mix are held constant at the values published in the CY 2026 OPPS final rule.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated starting with estimated 2025 outpatient payments as provided by CMS in the CY 2026 OPPS final rule. Estimated 2025 outpatient payments include outliers and the rural Sole Community Hospital (SCH) add-on, where appropriate.

The CY 2025 to CY 2026 percent change, for each outpatient payment change component analyzed, is calculated and applied to estimated CY 2025 payments. Generally, the percentage impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the percent change due to the market basket update is applied to total CY 2025 payments. Then, the percent change in the ACA-mandated market basket reduction is applied to the dollar result of the first change. This method continues for the remaining changes, creating a compounded effect. The difference between the results after each layered component is the impact of that component.

For changes to the OPPS rate and wage index, CY 2025 payments and volumes provided by CMS are divided into two parts based on the revenue and volumes from the CY 2024 SAF claims data in order to avoid applying market basket and wage index updates to payments not based on the OPPS conversion factor. The first part is made up of those services to which payment is based on the OPPS rate and is then adjusted by the changes to that rate and the wage index. The second part is made up of portion of those services for which payment is made outside of the rate (e.g., drugs paid at Average Sales Price+6%), which is held constant until changes to case mix and outliers are calculated. The percentage change for updates only applied to the conversion factor services in the analysis will vary based on the amount of conversion factor services a hospital provides relative to non-conversion factor services and therefore may differ from what CMS finalized.

Based on the limitations of CMS' OPPS Impact File, an "APC Factor/Updates" adjustment factor is calculated and used to estimate the value of payment changes that cannot be broken out by individual component. This hospital-specific factor/impact is derived by dividing total payments by the wage index and SCH add-on-adjusted conversion factor. The result of the first calculation is divided by the Medicare service count provided in the OPPS CY 2026 final rule Impact File. This factor impact represents the impact of changes to the APC assignments and weights and the outlier threshold.

Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than \$50 and percentages less than 0.05% will appear as zeros due to rounding.

This analysis does not include payment estimates for services provided to Medicare Advantage patients or modifications in FFS payments as a result of provider participation in new payment models being tested under

Medicare demonstration/pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods.