Medicare's 2026 ASC Payment Rule – What You Need to Know
December 5, 2025

Overview of the CMS 2026 Final Payment Rule

Laura Harris, MNASCA Executive Director, welcomed members to our final Member Forum of 2025 and introduced **Kara Newbury, Chief Advocacy Officer for the Ambulatory Surgery Center Association (ASCA).**

Newbury led the presentation, offering a detailed overview of the rule's major components, including Medicare inflation updates, expanded ASC-approved procedures, and significant revisions to the ASC Quality Reporting Program. She noted that the CMS 2026 Final Payment Rule was released on November 21 following the longest federal government shutdown in U.S. history.

Reimbursement Updates and Rate Adjustments

Newbury explained that ASCs will receive a **2.6% effective update across all procedures for 2026**, matching the update applied to hospital outpatient departments. CMS extended the Hospital Market Basket methodology for an additional year under the second Trump administration. Originally launched as a five-year trial in 2019 and extended two more years due to pandemic-related data issues, this update mechanism may soon face reevaluation. To prepare for potential changes in 2027, ASCA has engaged a research firm to refresh the cost-savings analysis.

CMS also finalized a **secondary rescaling factor of 0.872**, a meaningful improvement from the proposed 0.842, which would have resulted in an almost 16% reduction. CMS acknowledged an error in the proposed rule and corrected it in the final version.

Cataract Code Adjustment

One of the most notable changes involved **CPT 66984 (cataract surgery)**. The proposed rule indicated a 4.7% decrease, but national ophthalmic organizations identified calculation errors. After considering these concerns, CMS revised the final rate to a **3.4% increase**. Newbury noted that this discrepancy raises broader questions about potential issues in other codes. ASCA will conduct a more robust analysis of the highest-volume codes, which represent approximately **58% of Medicare fee-for-service ASC volume**.

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Expansion of Covered ASC Procedures

A major update for 2026 is the addition of **560 new procedure codes** to the ASC Covered Procedures List. CMS removed several categorical exclusion criteria and shifted greater responsibility to physician judgment, allowing case-specific determinations of procedural appropriateness. Additionally, CMS finalized **289 procedures** that are payable in the hospital outpatient department for ASC coverage—including 13 not listed in the proposed rule—such as cardioversion codes supported by ASCA.

CMS is also continuing the three-year phase-out of the inpatient-only list. For 2026, roughly **285 musculoskeletal procedures** will be removed, and **271** of these will be added directly to the ASC list. ASCA expects that only 20–30 of those will see meaningful utilization in practice. **Unlisted codes** remain the only major exclusion, as CMS cites administrative concerns about reviewing documentation from more than 5,600 ASCs.

New Nomination Process and ASCA Submissions

Newbury highlighted the updated nomination process, which began in 2024 and includes a March 1 deadline. ASCA successfully advanced several nominated codes—particularly in cardiology, spine, and vascular specialties—which have now been finalized for ASC use.

ASC Quality Reporting Program Changes

CMS finalized the removal of four measures from the ASC Quality Reporting Program.

- The COVID-19 vaccination measure (ASC-20) is being retired immediately; facilities that did not submit 2024 data will not be penalized in their 2026 payment adjustments.
- The three proposed health equity measures (ASC-22 through ASC-24) will also not move forward.

CMS declined to finalize the proposed patient-reported outcome (PRO) measure tied to information transfer. CMS acknowledged ASCA's concerns about survey fatigue, low OAS CAHPS response rates, and the measure's reliance on hospital—not ASC—data.

Total Joint Arthroplasty Patient-Reported Outcome Measure

The voluntary PRO measure for total hip and knee arthroplasty remains an area of concern due to significant operational burden. The measure requires data collection from **90 days pre-procedure through 425 days post-procedure**, with a 60% response threshold.

Newbury emphasized the difficulty of coordinating data that often resides with physician practices and reiterated ASCA's recommendation that CMS continue testing the measure within hospitals before extending it to ASCs.

Public Reporting Program Improvements

CMS collaborated with an external contractor to enhance the ASC Quality Reporting Program's public dashboard, resulting in a more user-friendly platform that allows facilities to compare performance across ASCs and hospital outpatient departments.

Copay Cap Legislation

Michael Miller raised the long-standing issue of copay disparities between ASCs and hospital outpatient departments. The current cap of $1,676 often leads patients to pay substantially more out-of-pocket for high-cost ASC procedures—sometimes up to $4,000 for specific neuro-stimulation codes. ASCA is actively pursuing legislation in both chambers of Congress to align ASC copay caps with those applied to hospital outpatient departments. However, Congressional scoring rules—which require CMS to recoup 20% of any reduced patient liability—remain a challenge. While momentum is growing, Newbury does not anticipate legislative action until 2026.

Resources and Follow-Up

Newbury will share an Excel file listing all **560 newly approved ASC codes** and welcomes follow-up questions directly via email.