CY 2027 OPPS/ASC Proposed Rule

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The proposed rule is scheduled for publication in the Federal Register on July 7, 2026. In addition to annual hospital outpatient and ambulatory surgical center payment updates, the rule proposes substantial changes involving the 340B Drug Pricing Program, site-neutral payments for hospital outpatient imaging, off-campus hospital departments, the inpatient-only list, prior authorization, hospital price transparency, and quality reporting. *[Proposed rule overview (PDF pages): 1-14.]*

I. 340B Drug Pricing Program

Background

The federal 340B Drug Pricing Program allows qualifying hospitals and other safety-net providers to purchase covered outpatient drugs from manufacturers at statutorily discounted prices. Medicare generally does not directly reimburse hospitals based on the price they paid for a drug. Instead, separately payable Part B drugs furnished in hospital outpatient departments have generally been reimbursed under the OPPS at the drug's average sales price, or ASP, plus 6%.

Between 2018 and September 27, 2022, CMS departed from this general policy and paid most affected 340B hospitals at ASP minus 22.5% for separately payable drugs acquired through the 340B program. CMS estimated that this policy reduced Medicare payments for 340B drugs by approximately $10.6 billion. To maintain OPPS budget neutrality, CMS simultaneously increased payments for other, non-drug outpatient services by approximately 3.19%.

In 2022, the Supreme Court held that CMS could not impose hospital-group-specific drug payment rates under the applicable statutory authority without first conducting a survey of hospitals' drug acquisition costs. CMS subsequently restored ASP-plus-6% payment for 340B drugs and issued approximately $9 billion in lump-sum remedy payments to hospitals that had been underpaid under the prior policy. Those remedy payments were made primarily in early 2024.

The CY 2027 proposed rule represents CMS's effort to reestablish substantially reduced 340B drug payments using the acquisition-cost survey authority identified by the Supreme Court. *[Proposed rule reference (PDF pages): 305-320 and 325-327.]*

New hospital drug acquisition-cost survey

CMS conducted an OPPS Drug Acquisition Cost Survey between January 1 and April 7, 2026. The refined survey population included 3,147 hospitals, of which 1,304 submitted data, for an overall response rate of 41.4%. Among approximately 1,508 identified 340B hospitals, 431 submitted usable data, producing a 340B response rate of 28.6%.

Based on the survey responses, CMS determined that the average acquisition cost of drugs purchased through the 340B program was approximately 33.4% below ASP. In contrast, reported acquisition costs for non-340B drugs were approximately 2.7% above mean ASP and 2.8% above median ASP. CMS also applied statistical weighting intended to account for differences between responding and nonresponding hospitals and concluded that the results supported using the 33.4% discount as a national payment adjustment. *[Proposed rule reference (PDF pages): 325-353.]*

Proposed 340B payment rate

Beginning January 1, 2027, CMS proposes to pay affected hospitals for separately payable drugs acquired through the 340B program at ASP minus 33.4%. Hospitals purchasing the same drugs outside the 340B program would generally continue to receive ASP plus 6%. CMS would not add an amount for pharmacy overhead, handling costs, inventory management, compliance expenses, or other hospital costs associated with acquiring and administering the drugs.

The proposed reduction would apply to separately payable drugs, biological products, biosimilar biological products, and certain separately payable radiopharmaceuticals acquired through 340B.

The reduction would not apply to vaccines, drugs receiving transitional pass-through payment, or qualifying non-opioid treatments for pain relief. If ASP information is unavailable, CMS proposes to calculate payment using wholesale acquisition cost minus 33.4%, or, when necessary, approximately 59.69% of average wholesale price. Existing reasonable-cost and invoice-based methodologies would generally remain unchanged. *[Proposed rule reference (PDF pages): 354-363.]*

Some Hospitals exempt from the reduction

CMS proposes to continue paying certain hospitals at the generally applicable ASP-plus-6% rate even when the drugs were purchased through 340B. The principal exemptions would cover:

- Rural sole community hospitals;
- Children's hospitals; and
- Prospective payment system-exempt cancer hospitals.

Critical access hospitals and rural emergency hospitals are not directly affected because they do not receive OPPS payment for these drugs under the standard methodology. CMS's stated rationale for the exemptions includes concerns about rural access, hospital financial vulnerability, specialized patient populations, and reliance on high-cost outpatient drug therapies. *[Proposed rule reference (PDF pages): 366-371.]*

Claim modifiers and hospital reporting

CMS proposes to use claim-level modifiers to distinguish among 340B and non-340B drugs:

- JG modifier: Drugs purchased through 340B and subject to the ASP-minus-33.4% payment rate.
- TB modifier: Certain 340B drugs exempt from the reduction, including drugs furnished by exempt hospitals, pass-through drugs, and qualifying non-opioid pain treatments.
- XX modifier: Drugs that were not purchased through the 340B program.

The reporting requirements would apply in both excepted and nonexcepted off-campus provider-based departments. Accurate modifier reporting would therefore become an important compliance issue because the modifier would directly determine the applicable Medicare payment rate. *[Proposed rule reference (PDF pages): 368-375.]*

Budget-neutral redistribution

CMS estimates that reducing payment for 340B-acquired drugs would decrease OPPS drug payments by approximately $4.85 billion in 2027. Because the acquisition-cost adjustment must be implemented in a budget-

neutral manner under the OPPS, CMS proposes to redistribute the estimated savings through an 8.44% increase in the OPPS conversion factor for non-drug services.

This redistribution is likely to create substantially different effects among hospitals. Hospitals with high volumes of separately payable 340B drugs could experience significant net payment reductions, particularly if their non-drug outpatient volume is insufficient to offset the drug reductions. Hospitals with relatively little 340B drug utilization but substantial non-drug OPPS volume could receive net increases. This is especially consequential because the 340B payment reductions are targeted to nonexempt 340B hospitals, while the increased non-drug conversion factor would generally apply across OPPS hospitals. *[Proposed rule reference (PDF pages): 377-379.]*

Beneficiary coinsurance

CMS projects that the lower payment rates for 340B drugs would reduce Medicare beneficiary cost-sharing by approximately $1.15 billion in 2027. Because beneficiaries generally owe 20% coinsurance on separately payable Part B drugs, the payment reduction would directly lower their out-of-pocket liability.

CMS illustrates the issue with Lupron. The agency reports an average ASP of approximately $4,690 and an average surveyed 340B acquisition cost of approximately $668. At ASP plus 6%, the Medicare payment would approach $4,971 and the beneficiary's 20% coinsurance could be about $994—more than the surveyed average amount the hospital paid for the drug. CMS cites such disparities as evidence that current payment can produce excessive Medicare and beneficiary expenditures when hospitals acquire drugs at deeply discounted 340B prices. *[Proposed rule reference (PDF pages): 363-366.]*

Acceleration of the separate 340B remedy offset

The proposed acquisition-cost policy is separate from CMS's ongoing effort to recoup the increased non-drug payments hospitals received during the 2018–2022 period. CMS previously estimated that hospitals received approximately $7.769 billion in additional non-drug payments because of the budget-neutrality adjustment accompanying the former ASP-minus-22.5% policy.

A 0.5% reduction to the OPPS conversion factor began in 2026 to recover that amount. At that rate, the recoupment would extend through approximately 2041. CMS now proposes to accelerate the reduction to 3% in 2027, which CMS estimates would recoup approximately $2.3 billion during 2027 and complete the full offset by the end of 2029. Hospitals that first enrolled in Medicare after January 1, 2018, would generally remain excluded from the remedy offset. CMS is also seeking comment on a less aggressive 2% alternative.

Consequently, affected 340B hospitals could face three simultaneous financial changes in 2027: the ASP-minus-33.4% drug rate, the 3% remedy-related reduction to non-drug OPPS payments, and the 8.44% budget-neutral increase in the general non-drug conversion factor. Hospitals will need to model these provisions together rather than evaluating any one adjustment in isolation. *[Proposed rule reference (PDF pages): 305-320.]*

II. Site-Neutral Payments

Existing site-neutral policy

Site-neutral payment refers to paying comparable amounts for the same service regardless of whether it is furnished in a physician office, hospital outpatient department, or another ambulatory setting. Medicare has traditionally paid substantially more under the OPPS for many services delivered in hospital outpatient departments than it pays under the Medicare Physician Fee Schedule for similar services delivered in physician offices.

Congress previously established lower payments for most services furnished in nonexcepted off-campus provider-based departments created or acquired after November 2, 2015. Those departments generally receive a Physician Fee Schedule-equivalent amount, currently calculated at approximately 40% of the full OPPS rate.

CMS has also extended site-neutral payments to selected services provided in older, "excepted" off-campus departments. Since 2019, clinic visits billed under HCPCS code G0463 in excepted off-campus departments have generally been paid at the Physician Fee Schedule-equivalent rate. Beginning in 2026, CMS expanded this approach to specified drug-administration services, while exempting rural sole community hospitals. *[Proposed rule reference (PDF pages): 415-419.]*

Proposed expansion to imaging without contrast

For 2027, CMS proposes another significant expansion by applying Physician Fee Schedule-equivalent payment to specified imaging services without contrast furnished in excepted off-campus hospital departments.

The proposal would apply to imaging services assigned to APCs 5521 through 5524 and to the following composite APCs:

- APC 8004: Ultrasound Composite;
- APC 8005: CT and CTA Without Contrast Composite; and
- APC 8007: MRI and MRA Without Contrast Composite.

Excepted off-campus departments would report the PO modifier, and payment for the affected services would be reduced to the Physician Fee Schedule-equivalent amount. Nonexcepted departments reporting the PN modifier already receive the lower payment and would therefore experience no comparable policy change. *[Proposed rule reference (PDF pages): 436-442.]*

CMS's justification

CMS states that many imaging procedures without contrast are high-volume, low- or moderate-complexity services that can be safely and routinely furnished in physician offices and freestanding imaging centers. The agency argues that large payment differences based solely on the ownership or location of the facility may encourage hospitals to acquire physician practices and imaging centers, convert them into hospital outpatient departments, and shift services into more expensive settings without a corresponding improvement in care.

CMS cites substantial payment differences. For example, Medicare's hospital outpatient payment for a transthoracic echocardiogram was approximately 294% higher than the physician-office payment in 2023. CMS also notes that a bone-density scan in 2025 could generate payment of roughly $30 in a physician office compared with approximately $106 under the OPPS.

The agency believes reducing these differences would lower Medicare spending and beneficiary coinsurance, reduce incentives for site shifting, and diminish the financial incentive for hospital acquisition of independent physician and imaging practices. *[Proposed rule reference (PDF pages): 419-435.]*

Estimated savings and rural exemption

CMS estimates that the imaging proposal would reduce 2027 expenditures by approximately $260 million, consisting of about $190 million in Medicare program savings and $70 million in beneficiary cost-sharing savings.

CMS projects approximately $7.2 billion in net Medicare Part B savings from 2027 through 2036. Unlike ordinary OPPS recalibration, the site-neutral reductions would not be redistributed through a budget-neutral

increase to other OPPS services. They would therefore represent direct reductions in aggregate Medicare spending.

Rural sole community hospitals would be exempt and would continue to receive the full OPPS amount, including the applicable 7.1% rural adjustment, for the affected imaging services. CMS cites the financial vulnerability of rural hospitals and the importance of preserving access in geographically isolated communities. *[Proposed rule reference (PDF pages): 442-445.]*

Broader implications

The imaging proposal continues CMS's service-by-service expansion of site-neutral payment into excepted off-campus departments. Although the immediate proposal is limited to imaging without contrast, CMS is soliciting comments on additional services and categories of hospitals that could be addressed under its statutory authority.

Hospitals with substantial off-campus imaging volume should assess the proposal by location, modifier, service code, APC assignment, rural status, and existing physician-office alternatives. Particular comment issues include whether hospital departments incur higher staffing, accreditation, standby capacity, emergency preparedness, technology, and regulatory costs that justify some payment differential, and whether reduced payment could impair access in underserved areas that do not qualify for the rural sole community hospital exemption. *[Proposed rule reference (PDF pages): 418-445.]*

Off-campus department identification and attestation

The proposed rule also discusses implementation of statutory requirements enacted in the Consolidated Appropriations Act of 2026. Beginning January 1, 2028, an off-campus hospital department generally would not qualify for OPPS payment unless it:

- Has a separate National Provider Identifier;
- Submits an initial provider-based attestation during the prescribed two-year implementation period; and
- Submits subsequent attestations at intervals established by CMS, no less frequently than once every five years.

CMS would be authorized to verify compliance through site visits, remote audits, and other review mechanisms. These requirements will give CMS more precise location-specific information and could support future payment, transparency, program-integrity, and site-neutral initiatives. *[Proposed rule reference (PDF pages): 591-604.]*

III. Other Major Provisions

OPPS and ASC payment updates

CMS proposes a 2.4% OPPS payment-rate increase for hospitals meeting applicable quality-reporting requirements. The increase reflects a projected 3.2% hospital market-basket update reduced by a 0.8-percentage-point productivity adjustment. Including anticipated changes in volume, case mix, enrollment, pass-through spending, and other factors, CMS estimates approximately $110.9 billion in total OPPS payments for 2027, an increase of about $9.5 billion from 2026.

When the effects of the proposed rule are evaluated without volume and case-mix growth, CMS estimates an average 1.9% payment increase across approximately 3,500 OPPS facilities. The effects vary significantly by hospital category: CMS estimates approximately a 6.4% increase for rural hospitals, a 2.4% decrease for major teaching hospitals, and a 10.6% increase for proprietary hospitals. Hospitals subject to the accelerated 340B remedy offset would collectively experience an additional estimated $2.3 billion reduction.

ASC payment rates would also increase by 2.4%, and CMS estimates total ASC payments of approximately $9.9 billion in 2027, an increase of about $520 million. CMS additionally proposes adding approximately 618 procedures to the ASC Covered Procedures List. *[Proposed rule reference (PDF pages): 8-9, 509-538, and 670-695.]*

Inpatient-only list

CMS proposes the second phase of its planned elimination of the Medicare inpatient-only list by removing approximately 637 additional services in 2027. Removal from the list does not require that a procedure be performed on an outpatient basis. Rather, it permits Medicare payment in an outpatient setting when the physician determines that outpatient treatment is clinically appropriate.

Hospitals will need to consider the effects on utilization review, inpatient admission decisions, two-midnight policy compliance, patient status notices, coding, quality measurement, and beneficiary cost-sharing. *[Proposed rule reference (PDF pages): 413-415.]*

Prior authorization

CMS proposes adding specified botulinum toxin injection services to the hospital outpatient prior-authorization program beginning July 1, 2027. The proposal reflects CMS's continuing expansion of prior authorization to service categories it considers vulnerable to unnecessary utilization, questionable billing, or improper payments. Hospitals and physician practices furnishing these services would need to incorporate the new authorization process into scheduling and treatment workflows. *[Proposed rule reference (PDF pages): 582-590.]*

Hospital price transparency

CMS includes a request for information on further changes to hospital price-transparency requirements. The agency is seeking input on improving the standardization, comparability, accuracy, and usefulness of hospital machine-readable files and consumer-facing displays.

The request addresses complex contractual terms such as stop-loss provisions, tiered rates, outlier payments, service carve-outs, bundled payments, and other arrangements that may make a single negotiated price misleading. CMS is also considering whether to revise the conditions under which hospitals are deemed compliant by maintaining an online price-estimator tool and whether additional standardization is needed for shoppable services and associated ancillary services. *[Proposed rule reference (PDF pages): 634-643.]*

Quality reporting and other provisions

CMS proposes removing the measure entitled "Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients" from both the Hospital Outpatient Quality Reporting Program and the ASC Quality Reporting Program. The rule also proposes changes to data validation and seeks information on possible future measures involving advance care planning. CMS does not propose substantive changes to the Rural Emergency Hospital Quality Reporting Program for 2027.

Other provisions include proposed adjustments addressing the higher cost of living in Alaska and Hawaii, review of 19 applications for device pass-through payment, and continuation of the 2026 payment level for three skin-substitute APC groupings because CMS concluded that sufficient new cost information was not available to support recalibration. *[Proposed rule reference (PDF pages): 195-255, 379-380, 462-466, and 539-572.]*