STRATEGIC HEALTH CARE

RE: CY 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule (CMS-1850-FC)

November 4, 2026

Executive Overview

CMS finalized substantial changes to Medicare outpatient reimbursement effective January 1, 2027. The two most consequential provisions are a reduction in payment for separately payable 340B-acquired drugs and expansion of site-neutral reimbursement for selected imaging services in grandfathered off-campus hospital outpatient departments. The final rule moderates certain proposed 340B cuts but retains the underlying policies.

1. 340B Drug Reimbursement: Significant Cut, Reduced From Proposal

CMS finalized reimbursement for affected 340B-acquired drugs at average sales price (ASP) minus 28%, compared with the proposed ASP minus 33.4% and the previous standard of ASP plus 6%. The final reduction is 34 percentage points relative to ASP, rather than the proposed 39.4 points. CMS based its policy on its 2026 hospital drug acquisition cost survey. Rural sole community hospitals remain exempt; critical access hospitals are outside OPPS.

The required budget-neutral offset increases payments for non-drug OPPS services by approximately 8.14%, versus the proposed 8.44%. Because 340B drug use and non-drug outpatient volume differ by hospital, this redistribution does not guarantee that individual 340B hospitals recover their losses.

2. Site-Neutral Imaging: Proposal Finalized

CMS finalized a Physician Fee Schedule-equivalent payment approach—generally about 40% of the full OPPS rate—for specified imaging without contrast performed at excepted (grandfathered) off-campus provider-based departments. The policy covers imaging APCs 5521–5524 and designated composite imaging APCs. The final rule retains the proposed rural sole community hospital exemption. CMS estimates an approximately 0.4% reduction in aggregate OPPS hospital payments attributable to the imaging policy, with larger effects possible for hospitals with substantial affected volume.

This extends site-neutral policy into previously grandfathered off-campus departments and may alter the economics of hospital-owned imaging networks. Hospitals should identify affected sites and codes and model their Medicare volume and reimbursement exposure.

3. Proposed Rule Compared With Final Rule

Policy	Proposed CY 2027	Final CY 2027
340B drug payment	ASP −33.4%	ASP −28%
340B non-drug offset	Approx. +8.44%	Approx. +8.14%
Prior 340B remedy recovery	3% annual reduction	2% annual reduction
Off-campus imaging	PFS-equivalent / ~40% OPPS	Finalized
Base OPPS rate update	2.4%	2.3%
Non-340B drugs	Generally ASP +6%	Generally ASP +6%
Rural sole community hospitals	Exempt from specified cuts	Exemptions retained

4. Accelerated Recovery of Earlier 340B Payments

CMS finalized an increase from 0.5% to 2% in the annual reduction applied to non-drug OPPS payments to recover approximately $7.8 billion in earlier budget-neutrality adjustments associated with the invalidated 2018–2022 340B policy. The proposed increase had been 3%. This adjustment generally applies to hospitals enrolled before January 1, 2018, rather than only to 340B participants. The reduction operates alongside the separate positive budget-neutrality adjustment associated with the new 340B drug payment cut.

5. Overall OPPS Payment Update and Distribution

The final standard OPPS payment-rate update is 2.3%, compared with 2.4% proposed. CMS projects approximately 1.7% aggregate growth in OPPS payments relative to 2026, but its modeled impacts differ considerably: urban hospitals approximately +1.3%; rural hospitals +5.3%; major teaching hospitals −2.7%; and nonteaching hospitals +6.0%. These are aggregate category estimates, not forecasts for particular facilities. Hospitals that fail outpatient quality reporting requirements remain subject to the applicable two-percentage-point update reduction.

6. Off-Campus HOPD Identification and Attestation Requirements

Mandatory payment condition beginning 2028. Section 6225 of the Consolidated Appropriations Act, 2026, makes compliance a prerequisite to Medicare payment for services furnished on or after January 1, 2028, by covered off-campus hospital outpatient departments (HOPDs). Each department must obtain its own National Provider Identifier (NPI), distinct from the main hospital's NPI, and services must be billed under that identifier. The hospital must submit a provider-based status attestation demonstrating compliance with 42 CFR § 413.65. Unlike the prior generally voluntary attestation process, submission becomes mandatory for affected departments.

Deadlines and repeat attestations. For departments operating on or before January 1, 2028, initial attestations must be submitted during January 1, 2026–December 31, 2027. Departments beginning services later must submit within the two years preceding the services. CMS retained a requirement for subsequent attestations at intervals not exceeding five years, but deferred detailed timing and procedures to the 2028 rulemaking cycle. A timely submitted attestation can satisfy the initial submission condition even if CMS has not yet issued a provider-based determination.

Submission, documentation and oversight. CMS finalized a standardized form and centralized electronic submission system; until available, hospitals may use the existing Medicare Administrative Contractor process. An authorized hospital official must attest; hospitals must first secure location-specific NPIs and update enrollment information. Supporting records generally need not accompany the initial submission, but must be retained and produced upon request. CMS may conduct risk-based reviews, remote audits, site visits and documentation checks addressing licensure, ownership and control, clinical and financial integration, public awareness, and other provider-based criteria. An adverse determination may result in payment recovery and appeal rights.

Scope and financial significance. The rule generally concerns off-campus departments, rather than on-campus locations or departments within 250 yards of a hospital remote location. CMS indicates the statutory requirement does not apply to critical access hospitals, provider-based rural health clinics, or AHEAD hospitals not paid under OPPS. Importantly, this attestation policy is separate from the 2027 site-neutral imaging cut: the imaging policy changes payment amounts, whereas the 2028 identification

and attestation policy can determine whether Medicare pays an affected department at all. CMS estimates approximately 16,488 initial attestations across 1,832 main providers, illustrating the compliance scale.

Comparison with proposal. CMS largely adopted the proposed NPI, attestation, centralized submission and review framework, but expressly clarified that a timely attestation can meet the submission requirement before CMS completes its status determination. CMS also retained the five-year outer limit for subsequent attestations while postponing the precise cadence and operational details.

7. Other Major Final Rule Policies

Surgical site of care. CMS continues its phaseout of the Medicare inpatient-only procedure list and expansion of procedures payable in ambulatory surgical centers. These changes permit more procedures to be paid in outpatient settings when clinically appropriate, but do not require clinicians to shift patients out of inpatient care. Hospitals should reassess the expected migration of eligible procedures and implications for outpatient surgical strategy.

Prior authorization. CMS finalized expansion of the hospital outpatient prior authorization program to additional botulinum toxin injection services. Hospitals should confirm affected codes, effective implementation dates, and internal authorization workflows.

340B drug reporting. The rule addresses use of claims modifiers to distinguish affected 340B drugs and other acquisition categories, including the ND modifier for drugs not acquired through 340B. Revenue-cycle teams should validate modifier instructions against the final CMS claims guidance.

Quality and compliance. The final rule also revises hospital outpatient and ASC quality reporting requirements and authorizes hospital accrediting organizations with deeming authority to assess certain administrative EMTALA requirements during surveys.

Source: CMS-1850-FC, CY 2027 OPPS/ASC Final Rule, Federal Register public inspection document 2026-22739 (November 2026): https://public-inspection.federalregister.gov/2026-22739.pdf.
Comparison: CMS-1850-P, CY 2027 proposed rule.