

## [ CY 2027 OPPS and ASC Payment System Proposed Rule



On July 2, 2026, the Centers for Medicare and Medicaid Services (CMS) issued the Calendar Year 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule. While the proposed payment update remains consistent with recent years, CMS proposes several

significant policy changes affecting hospital outpatient reimbursement. These include proposed reductions to 340B payments, expansion of site-neutral payment policies, and the continued phase-out of the inpatient-only list. The most significant proposals are outlined below.

### KEY TAKEAWAYS

- Rate increase of 2.4% for OPPS and ASC (before quality reporting penalties or sequestration)
- Major change to 340B drug reimbursement, with payment at ASP minus 33.4%
- Acceleration of 340B remedy offset to 3% annually
- Continued transition to outpatient services, with 637 services proposed to be removed from the Inpatient Only List and 618 procedures proposed to be added to the ASC Covered Procedures List
- Expansion of site-neutral payment policy to certain imaging services furnished in off-campus provider-based departments

### Payment Rate

The rule includes an increase of 2.4% for both the OPPS and ASC payment rates. This is consistent with last year and is based on a market basket increase of 3.2%, reduced by a 0.8 productivity adjustment. The payment rate will be reduced by 2% for hospitals and ASCs that fail to comply with applicable quality reporting requirements. Accordingly, the proposed OPPS and ASC conversion factors for 2027 are shown below. (The 340B Remedy Offset is addressed later in this article.) CMS estimates an **aggregate payment increase of \$9.5 billion from 2026 OPPS payments**, and an **increase of \$520 million from 2026 ASC payments**. However, the distribution of OPPS aggregate payments will be significantly impacted by some of the other

proposed changes. Below are the proposed conversion factors for providers that meet quality reporting requirements (Full Amount) and those that do not (Reduced Rate). *These rates do not reflect the impact of any sequestration adjustments, which are discussed in the next section.*

	Full Amount	Reduced Rate
<i>CY 2026 OPPS Conversion Factor</i>	\$ 91.415	\$ 90.967
CY 2027 Proposed OPPS Conversion Factor	\$ 102.004	\$ 100.015
CY 2027 Proposed OPPS Conversion Factor for Providers Subject to 340B Remedy Offset	\$ 99.015	\$ 97.085
<i>CY 2026 ASC Conversion Factor</i>	\$ 56.322	\$ 55.224
CY 2027 Proposed ASC Conversion Factor	\$ 57.766	\$ 56.638

CMS estimates that the overall impact of the ASC payment updates will differ depending on the specialty:

Surgical Specialty	Estimated Payment Increase
Nervous System	6%
Musculoskeletal	6%
Cardiovascular	5%
Genitourinary	1%
Eye	-1%
Gastrointestinal	-2%

*Derived from Table 89 in the CY 2027 Medicare Hospital OPPS and ASC Payment System Proposed Rule.*

The proposed rule also provides the expected payment changes for the thirty ASC procedures receiving the highest estimated aggregate Medicare payments in 2026. As shown below, the estimated payment swings vary drastically, from an increase of 36% to a decrease of 4%.

Selected Procedures	Short Description	Estimated Payment Change	Selected Procedures	Short Description	Estimated Payment Change
29827	Sho arthrs srg rt8tr cuf rpr	36%	43239	Egd biopsy single/multiple	(2%)
63685	Ins/rplc spi npg/rcvr pocket	15%	45380	Colonoscopy and biopsy	(2%)
64555	Implant neuroelectrodes	10%	45385	Colonoscopy w/lesion removal	(2%)
66991	Xcapsl ctrc rmvl insj 1+	10%	62323	Njx interlaminar lmb/sac	(2%)
0627T	Perq njx algc fluor lmb 1st	9%	65820	Relieve inner eye pressure	(2%)
64561	Implant neuroelectrodes	8%	66821	After cataract laser surgery	(2%)
64590	Ins/rpl prph sac/gstr npg/r	8%	66982	Xcapsl ctrc rmvl cplx wo ecp	(2%)
23472	Reconstruct shoulder joint	7%	66984	Xcapsl ctrc rmvl w/o ecp	(2%)
27279	Arthrd si jt perq/min nvas	7%	G0105	Colorectal scrn; hi risk ind	(2%)
64628	Trml dstrij ios bvn 1st 2 l/s	7%	G0121	Colon ca scrn not hi rsk ind	(2%)
27130	Total hip arthroplasty	6%	64483	Njx aa&/strd trfm epi l/s 1	(3%)
63650	Implant neuroelectrodes	6%	64493	Inj paravert f jnt l/s 1 lev	(3%)
27447	Total knee arthroplasty	5%	64635	Destroy lumb/sac facet jnt	(3%)
33285	Insj subsq car rhythm mntr	4%	64721	Carpal tunnel surgery	(3%)
36902	Intro cath dialysis circuit	(1%)	15823	Revision of upper eyelid	(4%)

*Derived from Table 90 in the CY 2027 Medicare Hospital OPPS and ASC Payment System Proposed Rule.*

## Sequestration Impact

It should be noted that the payment rates reflected in the OPPTS/ASC proposed rule are prior to any reduction for sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a given year results in an increase in projected budget deficits. PAYGO cuts to Medicare benefit payments would be capped at 4%. However, neither PAYGO nor any subsequent legislation includes details on how the two sequesters would be implemented together. The One Big Beautiful Bill Act signed into law last year would have triggered PAYGO in 2026 without additional Congressional action. However, Congress passed subsequent legislation that effectively cleared the scorecard to prevent PAYGO payment cuts.

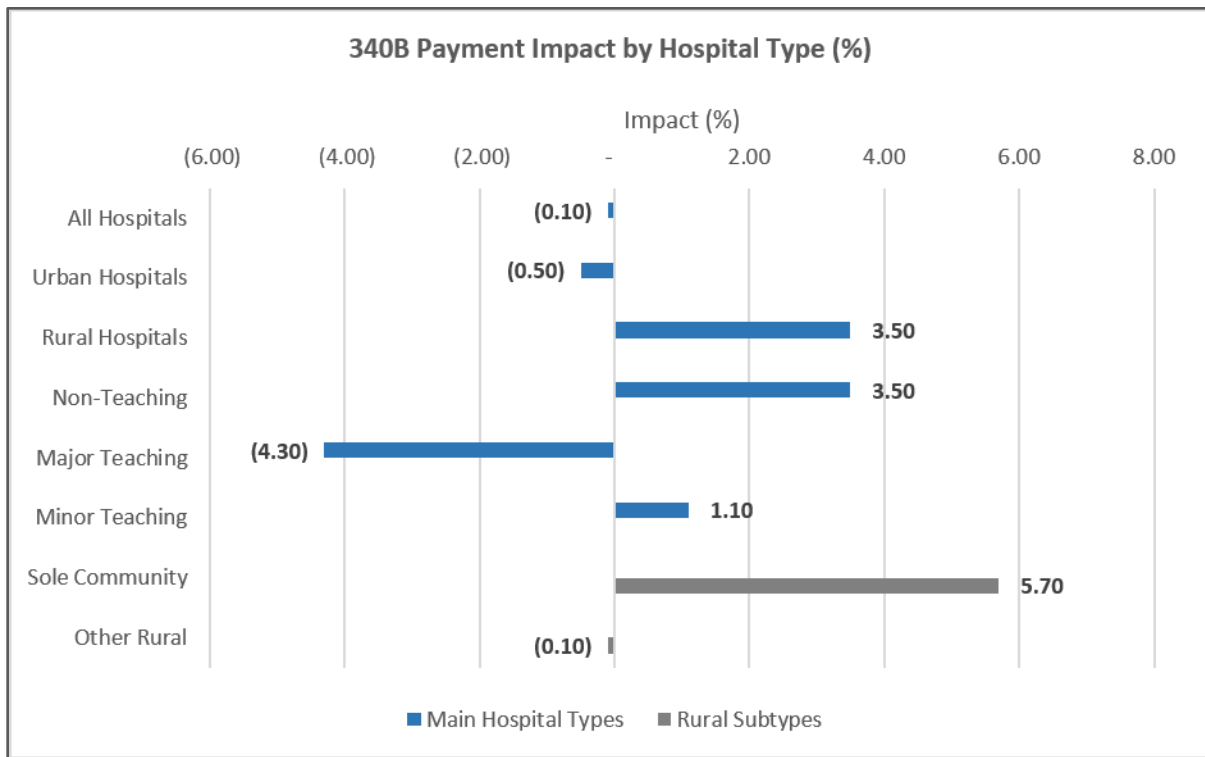
The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

## 340B-Acquired Drug Payment Methodology

Following completion of a hospital acquisition cost survey conducted earlier in 2026, CMS proposes paying **340B-acquired drugs at Average Sales Price (ASP) minus 33.4%** beginning in CY 2027, including 340B drugs furnished by nonexcepted off-campus provider-based departments. CMS states that survey results demonstrated substantial differences between acquisition costs for 340B and non-340B drugs and that this proposal would better align Medicare payment with hospital acquisition costs. Because the proposal must be budget neutral under statute, CMS would increase payments for non-drug OPPTS services by an equivalent amount. Specifically, the **conversion factor for OPPTS non-drug items and services is proposed to increase by 8.44% for 2027**. However, the proposed rule states that **“for most 340B providers, the decreased 340B drug payments will outweigh the increased payments for non-drug services.”** CMS estimates the 340B payment change would result in a **reduction in Medicare drug payments of around \$4.55 billion in the initial year, plus approximately \$1.15 billion reduction in beneficiary copayments.**

Importantly, CMS proposes that rural sole community hospitals, children’s hospitals, and PPS-exempt cancer hospitals would be exempted from the new 340B payment policy. Instead, these providers would generally continue to be reimbursed based on ASP plus 6%. Critical Access Hospitals and Rural Emergency Hospitals would also not be subject to the proposed 340B payment adjustment.

**This payment policy would result in a significant redistribution of payments among providers.** According to CMS estimates, the overall impact of the proposed 340B payment change on various provider types is as follows:



While the change would be generally positive for rural and non-teaching hospitals, major teaching hospitals would take a significant financial hit. However, even among rural hospitals there is great disparity, with sole community hospitals expected to receive a 5.7% increase (due to the exemption from the new 340B payment policy) while other rural hospitals would stay relatively unchanged from current levels.

## Remedy for the 340B-Acquired Drug Payment Policy

In 2018, CMS changed its methodology for determining payments for outpatient drugs acquired through the 340B program. The change in methodology resulted in a significant decrease in payments to hospitals. On June 15, 2022, the Supreme Court ruled that the payment rates paid by CMS in 2018 and 2019 were inappropriate, as the Department of Health and Human Services (HHS) did not have the authority to vary payment rates among groups of hospitals without a survey of the hospitals' acquisition costs. A survey was not conducted until 2020. Accordingly, CMS must make hospitals whole for the pay cuts they experienced in 2018 and 2019, which were around \$1.6 billion annually in aggregate.<sup>1</sup>

The 2024 OPPS and ASC final rule adopted an approach whereby CMS would make lump-sum payments, totaling around \$9 billion, to each of the approximately 1,700 hospitals that were impacted by the inappropriate payments. Notably, CMS maintained its position that the remedy has a statutory requirement for budget neutrality. To accomplish this, CMS decided to reduce future payments for non-drug items and services. After proposing a 2% reduction in the OPPS conversion factor starting in 2026 and continuing until the full \$7.8 billion budget neutrality adjustment is offset, CMS backed off in response to comments. Instead, the final rule for CY 2026 adopted a remedy offset adjustment of just 0.5%, resulting in a longer recoupment period estimated to be 16 years.

**The proposed rule makes a significant change to this approach by applying a 3% payment reduction to the conversion factor each year beginning in 2027. CMS estimates that increasing the 340B remedy offset from 0.5% to 3% will reduce payments for affected providers by approximately \$2.3 billion in 2027.**

<sup>1</sup> *American Hospital Assn. v. Becerra*, 596 U. S. \_\_\_\_ (2022)

CMS believes the accelerated recovery better aligns repayment with the hospitals that benefited from the original remedy payments and would complete recovery of the \$7.8 billion budget neutrality adjustment by CY 2029. Specifically, the proposed rule states that “as additional time elapses following the period during which the 340B Payment Policy was in effect, hospitals’ utilization of non-drug items and services is increasingly likely to diverge from their utilization patterns during that period,” and “the farther out these reductions apply, the less likely it is that the total recoupment for each hospital will align with the amount each hospital was overpaid. ... Consequently, it is less likely that the hospital would be restored to the financial position they would have been in had the 340B Payment Policy never been in effect. A total recoupment timeframe of 6 years would recover the funds in a manner that limits this divergence in utilization while avoiding the burden on providers that would result from a shorter recovery timeframe.”

## Changes to IPO & ASC Covered Procedures Lists

CMS plans to continue the three-year phase-out of the Inpatient Only (IPO) List. For 2027, the proposed rule would remove 637 services from the IPO, which represents about half of the services currently remaining on the IPO List. CMS expects the remaining services to be removed in CY 2028. The services proposed for removal in 2027 include several clinical families:

- Auditory
- Digestive
- Endocrine
- Female genital
- Hemic & lymphatic
- Integumentary
- Male genital
- Maternity care & delivery
- Mediastinum & diaphragm
- Respiratory
- Urinary

In addition, the proposed rule would add a total of 618 codes to the ASC-CPL for 2027.

## Site Neutrality

Beginning in 2027, CMS proposes paying for **imaging without contrast** services furnished in excepted off-campus provider-based departments at the **Physician Fee Schedule equivalent rate** rather than the OPSS rate. This proposal builds upon prior CMS policies affecting clinic visits and, more recently, drug administration services. (Rural Sole Community Hospitals would be exempt from this policy.)

The proposed change is estimated to reduce Medicare spending by \$260 million in 2027, reduce beneficiary premiums by \$70 million, and reduce beneficiary cost-sharing by around \$70 million. According to CMS estimates, there is not expected to be a tremendous disparity between provider types, with most hospital types receiving a reduction in payments of around 0.5% or less overall as a result of this policy change.

## Alaska & Hawaii COLA

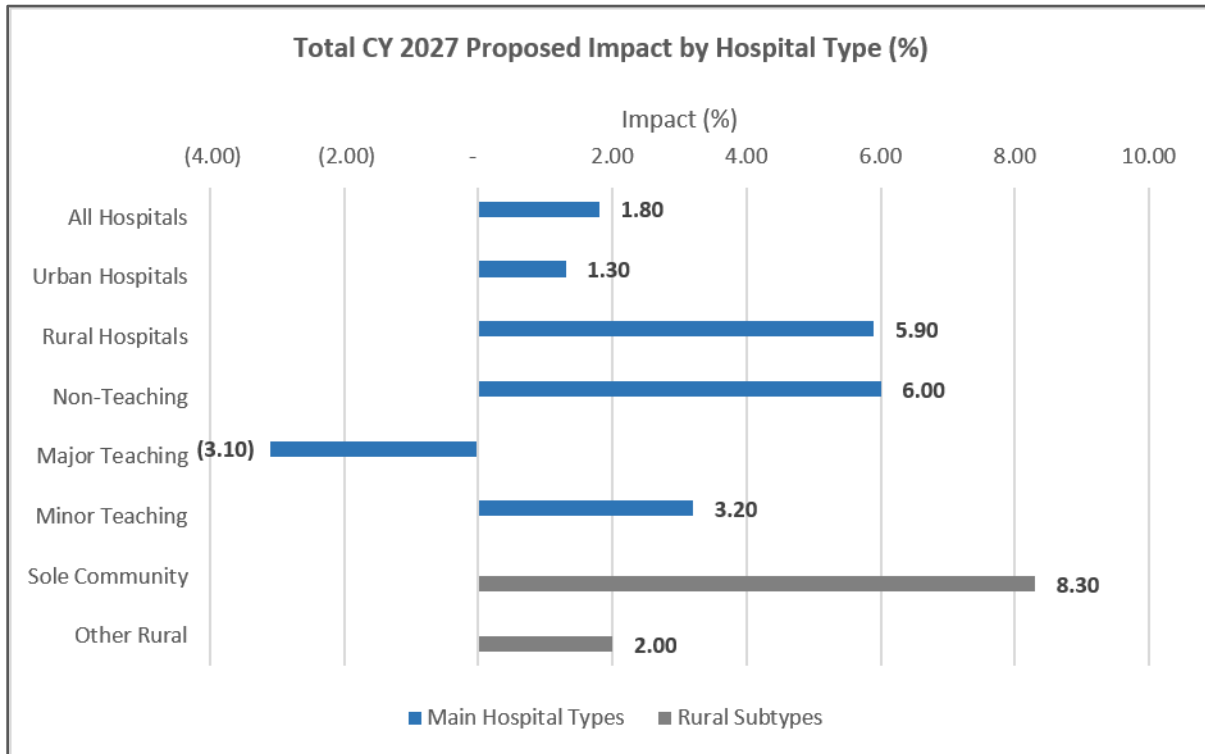
CMS proposes establishing a cost-of-living adjustment (COLA) for outpatient hospitals in Alaska and Hawaii to recognize higher nonlabor costs, aligning OPSS policy with the inpatient prospective payment system (IPPS). The proposal is subject to budget neutrality requirements, funded through a 0.9993 adjustment to the national OPSS conversion factor, and is projected to increase payments to Alaska and Hawaii hospitals by approximately **\$55 million** in CY 2027.

## Prior Authorization Expansion

CMS proposes expanding the Hospital Outpatient Department (HOPD) prior authorization process to include eight additional botulinum toxin (commonly known as Botox) injection codes beginning July 1, 2027. CMS states the proposal is intended to reduce unnecessary increases in service volume.

## Overall Impact of Proposed Changes

The proposed changes and associated budget neutrality adjustments result in a significant disparity among providers based on their circumstances. In particular, the change in 340B payment methodology yields wide swings in overall Medicare payments, as shown below:



## Industry Response

The American Hospital Association (AHA) released a statement noting “we are deeply concerned about CMS’ continued assault on the 340B drug pricing program, including its proposal to reduce 340B reimbursement rates by a shocking 33.4%.” The statement also expressed concern regarding the expedited clawback period for the 340B remedy as well as the expansion of site-neutral payment provisions.

Meanwhile, the Ambulatory Surgery Center Association (ASCA) noted that “despite the inflation update, this proposal would actually reduce payments for the most common procedures that ASCs perform.” While supportive of the proposed additions to the ASC Covered Procedures List, particularly four hernia codes, “the great majority of these procedures will still be performed in the hospital for the foreseeable future.”

*JTaylor’s healthcare consulting team includes experienced professionals who focus on strategy and operations for all types of providers. If you are interested in finding out how the CY 2027 OPSS/ASC Payment System proposed rule may impact reimbursement or your facility, we can help. Our team can also support you from a strategic perspective as you determine how to respond to the proposed changes in Medicare reimbursement. To find out more or to contact a member of our team, please visit our [website](#).*

**Resources:**

- [Fact Sheet](#): Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P). (2 July 2026).
- [Proposed Rule](#): Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; etc. (2 July 2026).
- [AHA Statement on CY 2027 OPPS Proposed Rule](#), American Hospital Association (2 July 2026).
- [CMS Disincentivizes Procedure Migration with Decline in Many Payment Rates](#), Ambulatory Surgery Center Association (2 July 2026).