# CY 2027 Hospital Outpatient Prospective Payment System (OPPS), CMS-1850-P Proposed Rule Summary

## Introductory Summary and Background

On July 2, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year (CY) 2027. The rule is in its entirety at the following link: https://www.federalregister.gov/public-inspection/2026-13656/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

## Key Proposals Effecting IR

- CMS proposed a 2.4 percent increase to the outpatient department (OPD) fee schedule for OPPS and Ambulatory Surgery Centers (ASCs).
    - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2 percent and a 0.8 percent productivity adjustment decrease.
- CMS proposed a conversion factor (CF) of $102.004 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) requirements; and applying the 2 percent reduction to those that do not with a CF equal to $100.015. CMS proposed a CF for Ambulatory Surgery Centers (ASCs) of $57.766 for ASCs meeting quality reporting requirements, and a CF of $56.638 for ASCs not meeting quality reporting requirements.
    - Due to prior rulemaking related to the 340B Remedy Offset, the proposed 2027 conversion factor (CF) for hospitals subject to this adjustment is $99.015. Additionally, CMS is proposing a 3 percent reduction to the conversion factor used to determine payment for non-drug items. This represents a change from the previously finalized 0.5 percent annual reduction that was implemented to offset payments for non-drug items made during 2018–2022. Additional details regarding the proposed changes to the 340B Program are provided below.
    - Ambulatory Surgery Centers (ASCs) are not impacted by any reduction due to the 340B offset remedy.
- CMS estimates total payments to OPPS providers will be approximately $110.9 billion, which is an increase of approximately $9.5 billion compared to CY 2026 OPPS payments.
- Cancer hospital payment-to-cost ratio (PCR) proposed for CY 2027 at 0.88 for the 11 designated hospitals.
- CMS proposes to reduce payment for imaging without contrast in the excepted provider-based department by the MPFS relativity adjustment to the OPPS payment rate, a reduction of 60% of the OPPS rate. This would apply to all codes in APCs 5521-5524, through APCs 8004-8005, and 8007.
- Proposal for several services in New Technology APCs to be reassigned to different APCs
    - LimFlow TADV procedure CPT Code 0620T proposed move to APC 1581
    - Liver Histotripsy Service CPT Code 0686T proposed move to APC 1575
    - Endovenous Femoral-Popliteal Arterial Revascularization with Placement of Stent Graft CPT code 0505T proposed move to APC 1580
- CMS proposed to maintain the per day cost threshold of $655 for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals.
- CMS proposed components of phase-II of the discontinuation of the inpatient only list (IPO) list. For CY 2027 this includes removal of 637 services, approximately half of the remaining 1,438 services still on the IPO list. The clinical families included in this list are auditory, digestive, endocrine, female

genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary.

- CMS proposed to continue the complexity adjusted payments for designated services performed in the ASC to provide a site neutral payment policy between outpatient hospital and ASC.
- CMS proposed to change the payment indicator for a service which SIR worked to create for IRs in the ASC. Based on claims data CPT code 60660 *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)* is predominantly performed in the office setting, it will be permanently assigned the status indicator "P2". When payment rates are set for this code in particular, values as defined under the Medicare Physician Fee Schedule will be used to set the rate, not values defined under OPPS.

## Payment Rates

CMS used the CY 2025 claims data for ratesetting for CY 2027 which follows the usual 2-year difference in data for ratesetting due to allowance for 1-year of timely filing for billing. The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges.

- CMS proposed a 2.4 percent increase to the OPD fee schedule for HOPPS and Ambulatory Surgery Centers (ASCs).
    - Based on the market update from the Inpatient Prospective Payment System (IPPS) of 3.2 percent and a 0.8 percent productivity adjustment decrease.
- CMS proposed a conversion factor (CF) of $102.004 for hospitals that meet the Hospital Outpatient Quality Reporting (OQR) requirements; and applying the 2 percent reduction to those that do not with a CF equal to $100.015. CMS proposed a CF for Ambulatory Surgery Centers (ASCs) of $57.766 for ASCs meeting quality reporting requirements, and a CF of $56.638 for ASCs not meeting quality reporting requirements.
    - Based on proposed 3 percent reduction as part of the Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 20128-2022.
    - Ambulatory Surgery Centers (ASCs) are not impacted by the 2 percent reduction for the 340B offset remedy.
    - Decrease in payment for drugs purchased under 340B Program, from average sales price (ASP) +6% to ASP -33.4%. Monies saved by decreasing what is paid to providers will be allocated to non-drug items.
    - Proposed payment savings for non-contrast imaging in excepted provider-based departments at 40% of the OPPS rate, a 60% reduction.
- CMS estimates total payments to OPPS providers will be approximately $110.9 billion, which is an increase of approximately $9.5 billion compared to CY 2026 OPPS payments.
- CMS proposed a CF for Ambulatory Surgery Centers (ASCs) of $57.766 for ASCs meeting quality reporting requirements, and a CF of $56.638 for ASCs not meeting quality reporting requirements.
- CMS proposed the establishment of a cost-of-living adjustment (COLA) for outpatient services in Alaska and Hawaii that parallels the COLA for inpatient services in these states, including any changes finalized in the FY 2027 Inpatient Final Rule to account for the exceedingly high cost of living in each of these states.

## Wage Index

CMS is proposing to continue the frontier state hospital wage index policy for CY 2027, which has been in effect since CY 2011. Under this policy, hospitals located in frontier states receive a wage index of 1.0000 if their otherwise applicable wage index is less than 1.0000. This adjustment recognizes the unique challenges associated with serving sparsely populated areas and helps ensure that hospitals in frontier states are not disadvantaged in reimbursement due to their low population density compared with hospitals in other states.

Consistent with the FY 2026 IPPS proposed rule, CMS finalized the discontinuation of the low wage index hospital policy under the OPPS beginning in CY 2026 and future years. As a result, CMS will no longer apply a low wage index budget neutrality factor to the OPPS standardized payment amounts.

In the FY 2027 IPPS proposed rule, CMS proposed to continue this transitional payment exception, noting that some hospitals that previously benefited from the low wage index hospital policy would still experience wage index decreases of approximately 5 percent or more annually compared with the FY 2024 wage index calculated under the former policy. Accordingly, CMS is proposing to continue the transitional payment exception under the OPPS for CY 2027.

## Procedures Assigned to New Technology APC Groups

When new technology is assigned a billing code, the establishment of a payment rate by CMS can be difficult because there is no claims data to determine utilization and cost by the hospital. Due to this, CMS created New Technology APCs which are similar to pass-through payments for new drugs, biologicals, radiopharmaceuticals and devices. The new technology is assigned to a temporary APC until claims data is available. Typically, this is a minimum of two years, but it can be less if there is sufficient data available sooner. Once there is sufficient data, the new technology is moved to a clinically appropriate APC.

### LimFlow TADV procedure, CPT Code 0620T (APC 1581)

The LimFlow Transcatheter Arterialization of the Deep Veins (TADV) procedure is an endovascular treatment for patients with chronic limb-threatening ischemia who are no longer candidates for conventional endovascular interventions or open bypass surgery to treat arterial blockages. For these patients, the only remaining treatment option is often limb amputation.

CY 2025 claims data showed 28 reported procedures, which remain below CMS's threshold of 100 annual claims for a service to no longer be considered low volume. As a result, CMS is proposing to assign the procedure to APC 1581 for CY 2027 with a payment rate of $55,000.50.

### Liver Histotripsy Service (APC 1575)

Liver histotripsy is reported using Category III CPT code 0686T. The procedure was initially reimbursed under the clinical study payment designation and has since transitioned to a New Technology APC. Claims data used for CY 2027 rate-setting show that the procedure exceeded CMS's low-volume threshold of 100 claims, with a total of 166 claims reported. As a result, CMS is proposing to transition the service to the standard APC rate-setting methodology and assign it to APC 1575 for CY 2027 with a payment rate of $12,500.50.

| HCPCS | Long Descriptor | Final CY 2026 OPPSAPC, SI | Proposed CY 2027 OPPSAPC, SI |
|---|---|---|---|
| **0620T** | Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed) | 1580, S | 1581, S |
| **0686T** | Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance | 1576, S | 1575, S |

**Endovenous Femoral-Popliteal Arterial Revascularization with Placement of Stent Graft, CPT Code 0505T**

Patients with advanced peripheral artery disease (PAD), including those with long, complex femoropopliteal artery stenoses or occlusions, may be treated using the DETOUR™ System, which is reported with Category III CPT code 0505T. When CPT code 0505T became effective, CMS established HCPCS code C1604 *(Graft, transmural transvenous arterial bypass (implantable), with all delivery system components)* to report the device as a transitional pass-through payment.

The pass-through payment for HCPCS code C1604 expires on December 31, 2026. Beginning in CY 2027, payment for the device will be packaged into the payment for the associated procedure. As a result, CMS must reevaluate the payment rate for CPT code 0505T to reflect the inclusion of the device cost.

**TABLE 28: FINAL CY 2026 AND PROPOSED CY 2027 STATUS INDICATOR ASSIGNMENT FOR CPT CODE 0505T**

| CPT® Code | Long Descriptor | Final CY 2026 APC, SI | Proposed CY 2027 APC, SI |
|---|---|---|---|
| **0505T** | Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion | 5193, J1 | 1580, S |

## Proposed Payment for Diagnostic Radiopharmaceuticals

In the CY 2025 HOPPS/ASC final rule, CMS finalized to pay for qualifying nonpass-through, separately payable diagnostic radiopharmaceuticals with per day costs above the threshold of $630. CMS proposed to continue this payment policy and maintain the CY 2026 threshold of $655 for CY 2027.

CMS included Table 4 which reflects the qualifying diagnostic radiopharmaceuticals with per day costs exceeding $655, as proposed for CY 2026, and are assigned a status indicator of “K”, which indicates a separate payment to be made based on the HCPCS code’s arithmetic MUC.

**TABLE 4: Proposed Qualifying Diagnostic Radiopharmaceuticals with Per Day Costs Exceeding $655**

| HCPCS Code | Short Descriptor | Proposed CY 2027 Status Indicator Assignment |
|---|---|---|
| A4642 | In111 satumomab | K |
| A9507 | In111 capromab | K |
| A9508 | I131 iodobenguate, dx | K |
| A9515 | Choline C 11, diagnostic | K |
| A9521 | Tc99m exametazime | E1* |
| A9532 | I125 serum albumin, dx | K |
| A9547 | In111 oxyquinoline | K |
| A9548 | In111 pentetate | K |
| A9551 | Tc99m succimer | K |
| A9554 | I125 iothalamate, dx | K |
| A9557 | Tc99m bicisate | K |
| A9569 | Technetium TC-99m auto WBC | K |
| A9570 | Indium In-111 auto WBC | K |
| A9572 | Indium In-111 pentetreotide | K |
| A9582 | Iodine I-123 iobenguane | K |
| A9584 | Iodine I-123 ioflupane | K |
| A9586 | Florbetapir F18 | K |
| A9587 | Gallium Ga-68 | K |
| A9588 | Fluciclovine F-18 | K |
| A9591 | Fluoroestradiol F 18 | K |
| A9592 | Copper cu 64 dotatate diag | K |
| A9593 | Gallium ga-68 psma-11 ucsf | K |
| A9594 | Gallium ga-68 psma-11, ucla | K |
| A9595 | Piflu f-18, dia 1 millicurie | K |
| A9596 | Gallium illuccix 1 millicure | K |
| A9601 | Flortaucipir inj 1 millicuri | K |
| A9602 | Fluorodopa f-18 diag per mci | K |
| A9608 | Flotufolastat f18 diag 1 mci | K |
| A9800 | Gallium locametz 1 millicuri | K |
| C9067 | Gallium ga-68 Dotatoc | K |
| Q9982 | Flutemetamol F18 | K |
| Q9983 | Florbetaben F18 | K |

*Proposed Status Indicator assignment is E1 until compliance with the Medicaid National Drug Rebate Agreement occurs. Once compliance is met, status indicator K would apply.

## Proposed Expansion of Site-Neutral Payment Policy

CMS continues to express concern that certain services are being furnished in the higher-cost hospital outpatient department (HOPD) setting when they could be safely and effectively provided in a physician office. According to CMS, the payment differential between these settings may create a financial incentive for providers to furnish services in provider-based departments (PBDs), resulting in unnecessary utilization of the outpatient hospital setting.

To address these concerns, CMS previously implemented a site-neutral payment policy by applying a Medicare Physician Fee Schedule (MPFS) equivalent relativity adjustment to services furnished in nonexcepted off-campus PBDs. Under this policy, which has been in effect since 2017, nonexcepted PBDs receive approximately 40% of the full OPPS payment rate, representing a 60% reduction.

More recently, CMS expanded this policy to excepted off-campus PBDs for drug administration services assigned to APCs 5691–5694. Rather than targeting individual HCPCS codes, CMS applied the payment adjustment to the entire APC family to better control utilization across all drug administration services.

For CY 2027, CMS is proposing to expand the site-neutral payment policy to include imaging services performed without contrast. CMS analyzed claims data and identified substantial growth in the use of these services in excepted off-campus PBDs. The proposal includes imaging procedures that do not require contrast administration and use standard imaging modalities, including radiography, ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), and dual-energy x-ray absorptiometry (DXA). CMS believe these services are generally low to moderate complexity and can be safely performed in multiple settings, including physician offices and hospital outpatient departments.

HCPCS code 77080 *(Dual-energy X-ray absorptiometry (DXA), bone density study, axial skeleton)* was identified as the most frequently billed imaging service without contrast in excepted PBDs. In CY 2025, the physician office payment rate for this service was approximately $30, compared with an OPPS payment rate of approximately $106, resulting in the hospital outpatient payment being more than three times higher. CMS also found that utilization of this service in excepted PBDs increased by more than 55 percent between 2016 and 2025, while utilization in physician offices declined by less than one-half percent. Based on these findings, CMS concluded that the payment differential, not population growth, is the primary driver of the increased outpatient volume.

Accordingly, CMS is proposing to apply the MPFS equivalent relativity adjustment to services assigned to the following APCs when furnished in excepted off-campus PBDs:

**TABLE 60: PROPOSED NEW APCS PAID THE PFS-EQUIVALENT RATE FOR SERVICES PROVIDED AT EXCEPTED OFF-CAMPUS PBDS FOR CY 2027**

| APC | APC Description |
|---|---|
| 5521 | Level 1 Imaging without Contrast |
| 5522 | Level 2 Imaging without Contrast |
| 5523 | Level 3 Imaging without Contrast |
| 5524 | Level 4 Imaging without Contrast |
| 8004 | Ultrasound Composite |
| 8005 | CT and CTA without Contrast Composite |
| 8007 | MRI and MRA without Contrast Composite |

CMS estimates that expanding the site-neutral payment policy to these APCs would generate approximately $260 million in savings during CY 2027, including $190 million in Medicare savings and $70 million in reduced beneficiary cost-sharing. Because Medicare Advantage payment rates have already been established for the year, CMS stated that this proposal would not affect Medicare Advantage payments. In addition, the policy would be implemented without budget neutrality.

Given the projected savings, CMS is also requesting public comments on other services that may be appropriate for future site-neutral payment policies to address similar site-of-service payment disparities.

## Eliminating the Inpatient Only (IPO) List

CMS believes that advances in medical practice and technology continue to allow more procedures to be performed safely in the outpatient setting with shorter recovery times. To expand beneficiary access and provide greater flexibility in selecting the most appropriate site of care, while potentially reducing out-of-pocket costs, CMS is proposing to phase out the Inpatient Only (IPO) List over a three-year period. The phase-out began in CY 2026 with the proposed removal of 285 primarily musculoskeletal procedures and is scheduled for completion by January 1, 2029.

Under this proposal, procedures removed from the IPO List may be reimbursed by Medicare when furnished in hospital outpatient departments or ambulatory surgical centers (ASCs), when clinically appropriate. This change provides physicians with greater flexibility in determining the most appropriate setting for patient care.

The procedures proposed for removal from the IPO List for CY 2027, along with their proposed status indicators and APC assignments (when applicable), are included in Addendum B of the proposed rule. The complete list of services that would remain designated as inpatient only for CY 2027 is available in Addendum E, both of which are posted on the CMS website.

CMS notes that, if finalized, most of the procedures remaining on the IPO List are more complex and may require additional evaluation before they can be safely transitioned to the outpatient setting. CMS also indicated that future removals may require revisions to existing APC assignments to ensure appropriate payment.

For interventional radiology, several procedures are proposed for removal from the IPO List effective January 1, 2027. The table below lists the interventional and diagnostic radiology codes identified in Addendum E that CMS has proposed removing from the IPO List. Although many of these procedures currently have low utilization, particularly within interventional radiology, the availability of outpatient reimbursement may increase procedure volumes as physicians gain additional flexibility in selecting the site of service.

| HCPCS Code | Short Descriptor |
|---|---|
| 47380 | Open ablate liver tumor rf |
| 49425 | Insert abdomen-venous drain |

## 340B Drug Discount Program

The 340B Program allows qualifying safety-net hospitals to purchase outpatient drugs at discounted prices. Historically, however, Medicare Part B reimbursed these drugs under the OPPS at standard rates without accounting for the lower acquisition costs, allowing 340B hospitals to retain the difference between reimbursement and purchase price.

To address this, CMS adopted payment reductions for 340B-acquired drugs beginning in 2018. Those policies were challenged in court, ultimately leading to the 340B Final Remedy Rule, which restored payments to affected hospitals for CYs 2018–2022 and established a budget-neutral method to recover the associated costs.

Under the Final Remedy Rule, CMS finalized a 0.5 percent annual reduction to the OPPS conversion factor for non-drug items and services beginning in CY 2026, with the expectation that the estimated $7.8 billion would be recovered over approximately 16 years. CMS later concluded this timeline was too lengthy because many hospitals that benefited from the higher payments may no longer participate in the program by the time recovery is complete.

Although CMS proposed increasing the annual reduction to 2 percent for CY 2026, the proposal was not finalized. For CY 2027, CMS is instead proposing a 3 percent reduction to the OPPS conversion factor for non-drug items and services (e.g., interventional radiology items and services). CMS estimates this approach will recover the remaining $7.769 billion by the end of CY 2029 and more closely aligns with the estimated 3.19 percent increase hospitals received for non-drug services during 2018–2022.

## Submitting Comments

Comments to CMS regarding the OPPS proposed rule must refer to file code **CMS-1850-P** and be received by **August 31, 2026**. Electronic and mail submissions are acceptable; electronic submissions are encouraged: https://www.regulations.gov/commenton/CMS-2026-2344-0001. Follow the instructions under the "submit a comment" tab.