Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2026

MEDICARE OPPS PROPOSED RULE

Overview and Resources

On July 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2027 proposed rule for the Medicare Outpatient Prospective Payment System (OPPS). The proposed rule includes updates to the Medicare fee-for-service OPPS payment rates based on changes set forth by CMS and those previously adopted by Congress. In addition to the regular updates to wage indexes and market basket, the policies being proposed in this rule include, but are not limited to:

- Updating Ambulatory Payment Classification (APC) groups and weights;
- Updating the 340B Remedy reduction to the OPPS conversion factor;
- Continuing the elimination of the Inpatient-Only (IPO) list;
- Expanding the method to control unnecessary increases in the volume of Outpatient Services;
- Reduce payments for 340B-Acquired drugs based on the Medicare OPPS Drug Acquisition Cost Survey; Updating requirements for the Hospital Outpatient Quality Reporting (OQR) Program; and
- Updating payment rates and policies for Ambulatory Surgical Centers (ASCs).

A summary of the major hospital OPPS sections of the proposed rule is provided below. Proposed program changes for CY 2027 would be effective on or after Jan. 1, 2027, unless otherwise noted. CMS estimates an increase of $1.82 billion in OPPS payments for CY 2027 over CY 2026. However, for providers subject to the 340B remedy offset, CMS estimates a further $2.3 billion reduction in payments in CY 2027.

The proposed rule and other resources related to the OPPS are available on the CMS website. An online version of this proposed rule is available here. Comments are due to CMS by Aug. 31, 2026, and can be submitted electronically at http://www.regulations.gov by using the website's search feature for "CMS-1850-P".

OPPS Payment Rates

CMS typically uses the most up-to-date claims data and cost report data to set OPPS rates for the upcoming year. CMS is proposing the use of CY 2025 claims data and CY 2024 Healthcare Cost Report Information System (HCRIS) data for CY 2027 OPPS rate setting.

The table below shows the final CY 2026 conversion factor compared to the proposed CY 2027 conversion factor.

	Final CY 2026	Proposed CY 2027	Percent Change
OPPS Conversion Factor	$91.415	$102.004	+11.58%
OPPS Conversion Factor with 340B Remedy Offset	$90.967	$99.015	+8.85%

The following table provides details of the proposed annual updates to the CY 2027 update factor.

Proposed CY 2027 Update Factor Component	Change to OPPS Conversion Factor
Market Basket (MB) Update	+3.2%
Affordable Care Act (ACA)-Mandated MB Productivity Adjustment	-0.8 percentage points (PPTs)
Removal of N95 Respirator BN*	+0.01%
Net Pass-through Spending Adjustment	+0.12%
Net Outlier BN	+0.00%
Wage Index BN	+0.98%
Wage Index 5% Stop Loss and Transitional Exception BN	-0.49%
COLA	-0.07%
Cancer Hospital BN	-0.06%
340B Drugs BN	+8.44%
Overall Proposed Rate Update	**+11.58%**
340B Remedy Offset	-2.93%
Overall Proposed Rate Update with 340B Remedy Offset	**+8.31%**

*CMS includes this adjustment in the calculation of the CY 2027 OPPS conversion factor but does not explicitly propose the removal of this adjustment.

The proposed market basket update percentage is based on IHS Global Inc.'s 1Q 2026 forecast with historical data through 4Q 2025.

Payment Adjustments For Non-Drug Items and Services as a Result of the 340B Payment Policy

The 340B Drug Pricing Program allows certain hospitals to purchase outpatient drugs at discounted prices. From CY 2018 to Sept. 27, 2022, CMS reduced payments for 340B-acquired drugs from Average Sales Price (ASP)+6% to ASP−22.5%. The Supreme Court ruled in *Bridgeport Hospital, et al., v. Becerra* that the payment reductions for 340B drugs were unlawful because CMS had not conducted a survey of hospital acquisition costs. In turn, CMS revised the payment policy to once again pay for 340B drugs at ASP+6% and provided a single-lump sum payment to affected hospitals to address the reduced reimbursement rates. To recoup the $7.8 billion increase that was made by CMS due to budget neutrality adjustments for all OPPS hospitals for non-drug items and services from CY 2018 to CY 2022, CMS adopted an annual prospective

payment reduction of 0.49 PPT to the OPPS conversion factor in the 340B Final Remedy Rule that was to start in CY 2026. Recoupment was estimated to take approximately 16 years.

In the CY 2026 OPPS rule making process, CMS proposed an increase to the annual reduction for non-drug items and services from 0.49 PPT to 2.0 PPTs but did not adopt its proposal. CMS did state that it anticipated a larger reduction being implemented in future years. As such, beginning with CY 2027 CMS is proposing to increase the annual reduction to the OPPS conversion factor from 0.49 PPTs to 2.93 PPTs. Under this revised rate CMS expects to recoup the $7.8 billion by the end of CY 2029.

Table 48 highlights the timeline for the proposed 2.93 PPTs and alternative 2.0 PPTs annual reduction.

Payment Increase for Rural Sole Community Hospitals (SCHS) and Essential Access Community Hospitals (EACHS)

CMS is proposing to continue the 7.1% budget neutral payment increase for rural SCHs and EACHs. This payment add-on excludes separately payable drugs, biologicals, brachytherapy sources, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. CMS would maintain this for future years until data supports a change to the adjustment.

Cancer Hospital Payment Adjustment and Budget Neutrality Effect

CMS provides payment increases to the 11 Inpatient PPS (IPPS) exempt cancer hospitals to address higher outpatient costs incurred by these hospitals. CMS does this by providing a budget neutral payment adjustment such that the cancer hospital's target payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for other non-cancer hospitals paid under the OPPS.

In the CY 2024 OPPS final rule, CMS adopted a policy to reduce the target PCR by 1.0 PPT each calendar year until the target PCR equals the PCR of non-cancer hospitals using the most recent data minus the 1.0 PPT as required by the 21st Century Cures Act. For CY 2027 CMS is proposing a target PCR of 0.88. Table 7 outlines the estimated percentage increase in OPPS payments for each cancer hospital for CY 2027 due to the cancer hospital payment adjustment policy.

Outllier Payments

To maintain total outlier payments at 1% of total OPPS payments, CMS is proposing an outlier fixed-dollar threshold of $7,100 for CY 2027, a 14.06% increase compared to the current threshold of $6,225. Outlier payments would continue to be paid at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiplier threshold and the fixed-dollar threshold are met.

Wage Index and Labor-Related Share

As in past years, CMS is proposing to continue to use federal fiscal year (FFY) 2027 IPPS wage indexes, including all reclassifications, add-ons, and rural floors to be applied to the labor-related share of CY 2027 OPPS payments in a budget neutral manner.

CMS applies a 5% cap on any decrease in the hospital wage index, compared to the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner nationally. This also means that if a hospital's prior wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the hospital's capped wage index in the prior year. Lastly, a new hospital will be paid the wage index for the area in which it is geographically located for its first full or partial year with no cap applied, because a new hospital will not have had a wage index in the prior year. CMS is proposing a budget neutrality factor of 0.9951 for the impact of the 5% cap on wage index decreases.

Separately, CMS is proposing a wage index and labor-related share budget neutrality factor of 1.0098 for CY 2027 to ensure that aggregate payments made under the OPPS are not greater or less than will otherwise be made if wage index adjustments had not changed.

The wage index is applied to the portion of the OPPS conversion factor that CMS considers to be labor-related. For CY 2027, CMS is proposing to continue to use a labor-related share of 60%.

CMS previously adopted a narrow transitional exception policy for hospitals that were significantly impacted by the discontinuation of the low wage index hospital policy. CMS is proposing to continue the transitional payment exception policy for CY 2027. If a hospital's CY 2027 wage index decreases by more than 9.75% from its CY 2024 wage index, the transitional payment exception is set to 90.25% of the CY 2024 wage index.

Updates to the APC Groups and Weights

As required by law, CMS must review and revise the APC relative payment weights annually. CMS must also revise the APC groups each year to account for drugs and medical devices that no longer qualify for pass-through status, new and deleted Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, advances in technology, new services, and new cost data.

The proposed payment weights and rates for CY 2027 are available in Addenda A and B of the proposed rule.

For CY 2027, CMS is proposing to recalibrate payment weights for services furnished on or after Jan. 1, 2027, and before Jan. 1, 2028, using the CY 2025 claims data.

The table below, based on Addendum A, shows the update in the number of APCs per category from CY 2026 to CY 2027:

APC Category	Status Indicator	Final CY 2026	Proposed CY 2027
Pass-Through Drugs and Biologicals	G	117	82
Pass-Through Device Categories	H	19	16
Non-opioid Medical Devices For Post-Surgical Pain Relief	H1	13	13
OPD Services Paid through a Comprehensive APC	J1	73	72
Observation Services	J2	1	1
Non-Pass-Through Drugs/Biologicals	K	526	549

Non-Opioid Drugs and Biologicals For Post-Surgical Pain Relief	K1	5	7
Partial Hospitalization	P	8	8
Blood and Blood Products	R	41	41
Procedure or Service, No Multiple Reduction	S	67	67
Slom Substitute Products	S1	3	3
Procedure or Service, Multiple Reduction Applies	T	29	29
Brachytherapy Sources	U	17	17
Clinic or Emergency Department Visit	V	11	11
New Technology	S/T	112	112
Total		1042	1028

Calculation of Cost-To-Charge Ratios (CCRS)

For CY 2027, CMS is proposing to continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs. CMS is also proposing to exclude cost report lines for non-standard cost centers in OPPS rate setting when hospitals have reported this data on cost report lines that do not correspond to the cost center number.

Blood and Blood Products

For CY 2027, CMS is proposing to continue its policy to establish payment rates for blood and blood products using a blood-specific CCR methodology.

Brachytherapy Sources

For CY 2027, CMS is proposing to continue its policy to use the costs derived from the most recent set of claims data (CY 2025) to set payment rates for brachytherapy sources. With the exception of brachytherapy source A9527 (Iodine i-125, sodium iodide solution, therapeutic, per millicurie), C2636 (brachytherapy linear source, non-stranded, palladium-103, per 1 mm), C2645 (brachytherapy planar source, palladium-103, per square millimeter), and low volume brachytherapy APCs, CMS is proposing to base payment rates on the geometric mean unit costs (MUCs) for each source. For CY 2027 and future years, CMS is also proposing to pay for the stranded and nonstranded not otherwise specified (NOS) codes, HCPCS codes C2698 (Brachytherapy source, stranded, not otherwise specified, per source) and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source), at a rate equal to the lowest stranded or nonstranded prospective payment rate for such sources, respectively, on a per-source basis.

CMS is also proposing to designate five brachytherapy APCs as low volume APCs.

Comprehensive APCS

A Comprehensive APC (C-APC) provides all-inclusive payments for certain procedures and covers payment for all applicable Part B services that are related to the primary procedure, including items currently paid under separate fee schedules. Each C-APC encompasses diagnostic procedures, lab tests, and treatments that assist in the delivery of the primary procedure; visits and evaluations performed in association with the procedure; coded and un-coded services and supplies used during the service; outpatient department services delivered by therapists as part

of the comprehensive service; durable medical equipment as well as the supplies to support that equipment; and any other components reported by HCPCS codes that are provided during the comprehensive service. The costs of blood and blood products are included in the C-APCs when they appear on the same claim as those services assigned to a C-APC. The C-APCs do not include payments for services that are not covered by Medicare Part B, nor those that are not payable under OPPS, such as: certain mammography and ambulance services; brachytherapy sources; pass-through drugs and devices; charges for self-administered drugs; certain preventive services; and procedures assigned to a New Technology APC either included on a claim with a "J1" or included on a claim with a "J2" indicator and packaged into payment for comprehensive observation services assigned to status indicator "J2".

For CY 2027 and subsequent years, CMS is proposing to exclude payment for cell and gene therapies from C-APC packaging, listed in Table 1, into the payment for the primary C-APC service on the same claim when those cell and gene therapies are not functioning as integral, ancillary supportive, dependent, or adjunctive to the primary C-APC service.

CMS is required to pay non-opioid pain relief drugs and devices separately instead of packaging them into C-APCs. The exclusion applies only to services furnished from Jan. 1, 2025, through Dec. 31, 2028. Qualifying products must have an FDA approved indication for postoperative or regional analgesia and evidence showing they reduce or replace opioid use. Products that do not meet these criteria will remain packaged under the standard C-APC payment policy.

Each year CMS reviews and revises the services within each APC group and APC assignments under the OPPS. CMS is not proposing to convert any standard APCs to C-APCs. The proposed CY 2027 C-APCs can be found in Table 2.

Composite APCS

Composite APCs are another type of packaging to provide a single APC payment for groups of services that are typically performed together during a single outpatient encounter. Currently, there are six composite APCs:

- Mental Health Services (APC 8010)
- Multiple Imaging Services (APCs 8004, 8005, 8006, 8007, and 8008)

For CY 2027, CMS is proposing to continue its policy that when the aggregate payment for specified mental health services provided by a hospital to a single beneficiary on a single date of service exceeds the maximum per diem payment rate for partial hospitalization services, those services would continue to instead be paid through composite APC 8010. In addition, CMS is proposing to continue setting the payment rate for composite APC 8010 to that established for APC 5864 (four or more hospital-based partial hospitalization services per day) as it is the maximum partial hospitalization per diem payment rate for a hospital.

CMS is proposing to continue its current composite APC payment policies for multiple imaging services from the same family and on the same date for CY 2027. Under this methodology, all qualifying imaging procedures within the same family are consolidated into a single composite APC payment. Table 3 lists the proposed HCPCS codes that would be subject to the multiple

imaging procedure composite APC policy, their respective families, and each family's geometric mean cost.

Universal Low Volume APC Payment Policy

For CY 2027, CMS is proposing to continue the universal low-volume APC payment methodology for services assigned to New Technology, clinical, and brachytherapy APCs with fewer than 100 single claims. This policy uses the highest of the geometric mean, arithmetic mean, or median based on up to four years of claims data to set the payment rate for the APC. The proposed low volume APCs for CY 2027 can be found in Table 23.

Payment For Medical Devices with Pass-Through Status

There are currently 21 device categories that are eligible for pass-through payment. A full list of these devices and their pass-through status expiration dates can be found in Table 29.

CMS received 19 applications for device pass-through payment applications by the Mar. 2, 2026, deadline. CMS is proposing to deny device pass-through payment status for six applications. CMS is also proposing to approve device pass-through payment status for seven applications that were preliminarily approved for pass-through payment status during the quarterly review process:

- Esprit™ BTK Everolimus Eluting Resorbable Scaffold System
- MY01 Continuous Compartmental Pressure Monitor
- RemeOs™ Screw LAG Solid
- SetPoint System
- TOPS™ System
- TOUCH® CMC 1 Prosthesis
- WiSE® CRT System

Device-Intensive Procedures

CMS is proposing to continue the device-intensive procedures policies for CY 2027. The full list of the proposed CY 2027 device-intensive procedures can be found in Addendum P of this proposed rule.

CMS is proposing to continue the device edit policy for CY 2027 with no modifications.

Payment Adjustment for No Cost/Full Credit and Partial Credit Devices

For outpatient services that include certain medical devices, CMS reduces the APC payment if the hospital receives a credit from the manufacturer. The offset can be 100% of the device amount when a hospital attains the device at no cost or receives a full credit from the manufacturer; or 50% when a hospital receives partial credit of 50% or more. CMS determines the procedures to which this policy applies, using three criteria:

- All procedures must involve implantable devices that will be reported if device-insertion procedures were performed;

- The required devices must be surgically inserted or must be implanted devices that remain in the patient's body after the conclusion of the procedure (even if temporarily); and
- The procedure must be device-intensive (devices exceeding 30% of the procedure's average cost).

For CY 2027, CMS is proposing to continue the no cost/full credit and partial credit device policies with no modifications.

Payment for Drugs, Biologicals and Radiopharmaceuticals

CMS pays for drugs and biologicals that do not have pass-through status in one of two ways: either packaged into the APC for the associated service or assigned to their own APC and paid separately. The determination is based on the packaging threshold. CMS allows for a quarterly expiration of pass-through payment status of drugs and biologicals newly approved in order to grant a pass-through period as close to a full three years as possible, and to eliminate the variability of the pass-through payment eligibility period without exceeding the statutory three-year limit.

For CY 2027 and subsequent years CMS is proposing to use the existing methodology to calculate the per day costs for diagnostic radiopharmaceuticals. Consistent with methodology and practices, CMS is proposing to update the diagnostic radiopharmaceutical packaging threshold to $665 for CY 2027. In addition, CMS is proposing to continue to pay radiopharmaceuticals with per day costs above the diagnostic radiopharmaceutical packaging threshold, based on their arithmetic MUC, derived from CY 2025 claims data.

Separately for CY 2027, CMS is proposing a packaging threshold of $140. Drugs, biologicals, and radiopharmaceuticals (excluding diagnostic radiopharmaceuticals) that are above the $140 threshold are paid separately, using individual APCs, and those below the threshold are packaged; the baseline payment rate for CY 2027 is the ASP+6%. Separately payable drugs and biological products that do not have pass-through status would be paid wholesale acquisition cost (WAC)+3%.

For CY 2027, CMS is proposing to continue paying for blood clotting factors and therapeutic radiopharmaceuticals without pass-through payment status at ASP+6%. If ASP data are not available, payment instead will be made at WAC+3%; or 95% of average wholesale price (AWP) if WAC data are also not available.

For CY 2027 and subsequent years, for those HCPCS codes for drugs, biologicals and therapeutic radiopharmaceuticals that are impacted by the updated drug packaging threshold, CMS is proposing the following:

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2026 and that are proposed for separate payment in CY 2027, and that then have per day costs equal to or less than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule, would continue to receive separate payment in CY 2027.

- HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2026 and that are finalized for separate payment in CY 2027, and that then have per day costs equal to or less than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule, would remain packaged in CY 2027.
- HCPCS codes for drugs, biologicals, and radiopharmaceuticals for which we finalized packaged payment in CY 2027 but that then have per-day costs greater than the CY 2027 final rule drug packaging threshold or diagnostic radiopharmaceutical packaging threshold, based on the updated ASPs and hospital claims data used for the CY 2027 final rule, would receive separate payment in CY 2027.

For CY 2027, CMS is proposing to continue to pay for non-pass-through diagnostic radiopharmaceuticals that are separately payable. CMS will continue to use MUC data for radiopharmaceuticals that are finalized as separately payable due to their cost exceeding the per-day threshold.

Additionally, CMS is proposing to maintain the policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis for HCPCS codes that describe the same drug or biological but different dosages. CMS is also proposing this policy to apply to diagnostic radiopharmaceuticals.

There are 49 drugs and biologicals for which pass-through payment status will expire by Dec. 31, 2026, as listed in table 43. For CY 2027, CMS is proposing to end pass-through payment status for 28 drugs and biologicals listed in Table 44. Additionally, CMS is proposing to continue pass-through payment status through CY 2027 for 45 drugs and biologicals listed in Table 45.

Packaged Items and Services

CMS is proposing to continue to conditionally package costs of selected newly identified ancillary services into payment for a primary service where CMS believes the packaged item or service is integral, ancillary, supportive, dependent, or otherwise adjunctive to the primary service.

For CY 2027, CMS is proposing to continue to unpackage, and pay separately at ASP+6%, the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in the ASC setting. These drugs are only eligible if the drug or biological does not have transitional pass-through payment status and the drug must not already be separately payable in the OPPS or ASC payment system. Table 71 lists the qualifying products for separate payment in the ASC setting under this policy for CY 2027.

Skin Substitutes

In the CY 2026 OPPS final rule, CMS adopted a policy to separately pay for certain groups of skin substitute products as incident-to supplies under the Medicare Physician Fee Schedule (MPFS) in the non-facility setting or the OPPS in the hospital setting. This included unpackaging the skin substitute products from the payment for administration of the skin substitute product separate from the skin substitute product itself. CMS removed skin substitutes from the list of packaged

items and services and specified that payment would continue to be packaged for products that aid wound healing that are not skin substitute products.

As part of the policy, skin substitutes that are not drugs or biologicals are grouped into three APCs:

- APC 6000 (PMA Skin Substitute Products)
- APC 6001 (510(k) Skin Substitute Products)
- APC 6002 (361 HCT/P Skin Substitute Products)

An initial payment rate of $127.14 was established for these three APCs, with the stated intention of updating the rates annually using the most recently available calendar quarter of ASP data. Currently CMS does not believe there is sufficient data to propose a revised payment rate. Therefore, for CY 2027 CMS is proposing to continue the policy adopted in CY 2026, which includes maintaining the payment rate of $127.14 for the three APCs listed above.

Payment For Off-Campus Outpatient Departments (OPDS)

To control what CMS deemed an unnecessary increase in OPPS service volume for a basic clinic visit representing a large share of the services provided at off-campus provider-based departments (PBDs), CMS expanded the MPFS payment methodology in CY 2019 to excepted off-campus PBDs for HCPCS code G0463. As of CY 2024, this policy has the following additional exemptions:

- Excepted off-campus PBDs belonging to rural SCHs;
- Application of the community mental health center (CMHC) per-diem rates for hospital partial hospitalization program (PHP) and intensive outpatient (IOP) services provided at an off-campus PBD, instead of the MPFS rate for that service; and
- Payment made for intensive cardiac rehabilitation (ICR) services.

In the CY 2026 OPPS final rule, CMS adopted an extension of this policy to drug administration services furnished in excepted off-campus PBDs.

In the past, CMS has sought comment on the appropriateness of addressing unnecessary volume increases for covered OPD services in off campus PBDs. Currently, CMS believes that there has been an unnecessary increase in the volume of imaging without contrast services paid under the OPPS. Therefore, for CY 2027, CMS is proposing to apply the MPFS equivalent payment rate to HCPCS codes assigned to services paid through the following APCs when furnished at an off-campus PBD.

- APC 5521—Level 1 Imagine without Contrast
- APC 5522—Level 2 Imagine without Contrast
- APC 5523—Level 3 Imagine without Contrast
- APC 5524—Level 4 Imagine without Contrast
- APC 8004—Ultrasound Composite
- APC 8005—CT and CTA without Contrast Composite
- APC 8006—MRI and MRA without Contrast Composite

CMS is proposing to continue to exempt rural SCHs from the proposed method.

PHP and IOP Services

The PHP is an intensive outpatient psychiatric program that provides outpatient services in place of inpatient psychiatric care. PHP services may be provided in either a hospital outpatient setting or a freestanding CMHC. PHP providers are paid on a per-diem basis with payment rates calculated using CMHC-specific or hospital-specific data.

As required by the Consolidated Appropriations Act (CAA) of 2023, CMS previously adopted payment and program requirements for intensive outpatient program services beginning CY 2024. Intensive outpatient services are furnished under a distinct and organized outpatient program of psychiatric services for individuals who have an acute mental illness, called an IOP. IOP services are less intensive than PHP services and can be furnished by a hospital to its outpatients, a CMHC, a federally qualified health center, or a rural health clinic.

The table below compares the final CY 2026 and proposed CY 2027 PHP and IOP payment rates as found in Addendum A:

	Final Payment Rate 2026	Proposed Payment Rate 2027	% Change
APC 5851: Intensive Outpatient (3 services) for CMHCs	$127.74	$139.81	+9.45%
APC 5852: Intensive Outpatient (4+ services) for CMHCs	$167.38	$185.98	+11.11 %
APC 5853: Partial Hospitalization (3 services) for CMHCs	$127.74	$139.81	+9.45%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	$167.38	$185.98	+11.11 %
APC 5861: Intensive Outpatient (3 services) for Hospital-based IOPs	$319.38	$349.52	+9.44%
APC 5862: Intensive Outpatient (4+ services) for Hospital-based IOPs	$418.45	$464.99	+11.12 %
APC 5863: Partial Hospitalization (3 services) for Hospital-based PHPs	$319.38	$349.52	+9.44%
APC 5864: Partial Hospitalization (4+ services) for Hospital-based PHPs	$418.45	$464.99	+11.12 %

For CY 2027, CMS is proposing to maintain the current methodology to calculate the CY 2027 geometric mean per diem costs based on 40% of the corresponding hospital-based PHP and IOP APCs.

Additionally, CMS is proposing to continue making outlier payments to CMHCs for 50% of the amount by which the cost for the PHP service exceeds 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year. CMS is also proposing to maintain the CMHC outlier payment cap at 8% of the CMHC's total per diem payments and proposing to continue including both PHP and IOP in the calculation of the CMHC outlier percentage.

Inpatient-Only (IPO) List

The IPO list specifies services/procedures that Medicare will only pay for when provided in an inpatient setting. In the CY 2026 OPPS final rule CMS adopted the elimination of the IPO list through a three-year transition, beginning in CY 2026 and completing the elimination by Jan. 1, 2029. For CY 2027, CMS is proposing to continue the second phase of elimination and remove 637 services from the IPO list. The list of proposed procedures for removal for CY 2027 is available here.

OPPS Payment Status and Comment Indicators

For CY 2027 and subsequent years CMS is proposing to revise the current definition of "E2" status indicator to comply with the drug invoice policy. CMS is also proposing to create a new "O1" status indicator for software as a medical service that is paid separately under the OPPS. Table 63 outlines the proposed definition and proposed payment status of these two status indicators. Lastly, CMS is also proposing to continue using four comment indicators for the CY 2027 OPPS:

- "CH"—Active HCPCS code in current and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.
- "NC"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year for which we requested comments in the CY 2026 OPPS/ASC proposed rule; final APC assignment; comments will not be accepted on the final APC assignment for the new code.
- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
- "NP"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, as compared to current calendar year, proposed APC assignment; comments will be accepted on the proposed APC assignment for the new code.

Payment For High-Cost Drugs Provided by Indian Health Service (HIS) and Tribal Facilities

For CY 2027, CMS is proposing to continue its policy that IHS and tribal hospitals receive separate payment for high-cost drugs furnished in hospital outpatient departments through an additional add-on payment using the authority under which the annual All-Inclusive Rate (AIR) is calculated. This add-on payment is applicable to all Medicare Part B-covered high-cost drugs furnished in IHS/tribal hospital outpatient departments that would otherwise be paid for under OPPS, for whose per-day cost exceeds twice the lower 48 states' AIR in effect at the time of release of the CY 2027 OPPS final rule. This payment is in addition to the AIR and will have no impact on the calculation of the AIR.

Addendum Q includes a preliminary list of drugs qualifying for the proposed add-on payment and their respective payment rates for CY 2027.

Removals From the Hospital OQR and ASCQR Program Measure Sets

Beginning with the CY 2027 reporting period/CY 2023 payment determination, CMS is proposing to remove the "Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients" measure from the Hospital OQR and ASCQR programs.

Updates to the OQR Program

The OQR program is mandated by law; hospitals that do not successfully participate are subject to a 2.0 PPT reduction to the OPPS market basket update for the applicable year.

CMS is proposing to incorporate the validation of eCQM data into the OQR program's existing validation process which includes:

- Changing validation selection pool from 500 hospitals (450 selected at random and 50 selected using targeting criteria) to up to 400 hospitals (200 selected at random and 200 selected using targeting criteria);
- Clarify application of the targeting criteria to eCQMs;
- Update the number of cases for chart-abstracted and eCQM validation;
- Include eCQM validation in the timing and submission of medical record requests;
- Align the submission quarters for chart-abstracted and eCQM validation;
- Establish an eCQM validation scoring method based on data accuracy; and
- Update the educational review process for validation results.

RFI – Emergency Care Access and Timeliness ECQM

CMS is seeking input on the importance, relevance, appropriateness, and applicability of quality measure topic related to advanced care planning, a continuous process that supports people in understanding and communicating goals, values, and preferences regarding future medical decisions. CMS is also seeking input on the relevant aspects of advanced care planning and measures appropriate for the Hospital OPD (HOPD) setting.

Rural Emergency Health (REH) Quality Reporting Program

The REH Quality Reporting Program is mandated by the CAA of 2021. CMS is not proposing any updates to the program at this time.

Accrediting Organization (AO) Deeming Authority For the Emergency Medical Treatment and Labor Act (EMTALA)

The EMTALA was created to address concerns regarding inappropriate transfer of, or refusal to treat individuals with emergency medical conditions who are seeking emergency department care. Hospitals, including Critical Access Hospitals (CAHs) and REHs must agree to comply with EMTALA's statutory and regulatory requirements to be enrolled and participate in Medicare.

CMS is proposing that AOs with CMS-approved accrediting programs for hospitals may assess compliance with the EMTALA-related administrative requirements, including required signage display, maintenance of an emergency department log, retention of transfer records, and maintenance of an on-call physician list as part of their accreditation and reaccreditation surveys. Under this proposal CMS and the Office of Inspector General would retain enforcement authority.

Expansion of Botulinum Toxin Injection Codes for HOPD Prior Authorization Process

As part of routine data analysis CMS discovered that claim volumes for Botulinum Toxin Injection codes increased by 42.8% between 2017 and 2024. After review, CMS concluded that the increases in volume for Botulinum Toxin Injections are unnecessary and is proposing to add prior authorization requirements for eight additional botulinum tox PHP in injection codes listed on Table 76. The full list of outpatient services that currently require prior authorization may be found in Table 77.

Requirements For Provider-Based Status

Effective CY 2028, the CAA of 2026 prohibits Medicare OPPS payments to off-campus outpatient departments that do not meet the following requirements:

- Bill using a separate National Provider Identifier (NPI) from the main provider NPI;
- Main provider has submitted an initial provider-based status attestation confirming compliance with requirements; and
- Main provider has submitted a subsequent attestation within the timeframe defined by the Secretary.

As such, CMS is proposing to add a new definition for an "Off-Campus outpatient department of a provider" as a department of a provider that is not located on the campus of the main provider or within 250 yards of a remote location of a hospital.

CMS also proposes to add a requirement that the main provider must submit an initial attestation of provider-based status for each of its off-campus outpatient departments within the two-year period prior to furnishing services, and subsequent attestation(s) within a period not to exceed 5 years thereafter. For all off-campus outpatient departments that provide services on or before Jan. 1, 2028, an initial attestation must be submitted between Jan. 1, 2026, and Dec. 31, 2027. For off-campus outpatient departments that begin providing services after Jan. 1, 2028, an attestation must be submitted within the two years prior to when the billed services are delivered.

Additionally, CMS proposes a standardized attestation form for provider-based determinations that would replace the current Medicare Administrative Contractor (MAC) specific templates. Under this proposal, main providers would submit the attestation through a centralized electronic system. CMS also proposes to modify the current attestation process so that CMS "or its agents" will send the provider written acknowledgement of receipt of the attestation, review the attestation for completeness and consistency with information in the possession of CMS ''or its agents'' at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based. Supporting documentation may be requested by CMS and its contractors, including MACs, at any stage of the review, validation, audit or oversight process to evaluate compliance with provider-based requirements. Failure to submit requested documentation within the timeframe specified by CMS may result in a determination of non-compliance.

Graduate Medical Education (GME)

CMS is providing public notification of the closure of a teaching hospital for the purpose of the established application process for the resident slots attributed to this hospital.

CCN	Provider Name	City/State	CBSA	Terminating Date	IME Cap (includes all adjustments)	Direct GME Cap (includes all adjustments)
140082	Louis A. Weiss Memorial Hospital	Chicago, IL	16984	Aug. 9, 2025	85.82	66.79

Potential Approaches for Separate IPPS Payment For Domestic Procurement of Personal Protective Equipment (PPE) and Essential Medicines

In the "Ensuring Safety Through Domestic Security With Made in America Personal Protective Equipment (PPE) and Essential Medicine Procurement by Medicare Participating Hospitals" advance notice of proposed rulemaking (91 FR 3851), CMS sought public comment on potential options to consider for Medicare-participating hospitals to help foster a more resilient supply chain for American-made PPE and essential medicines to secure our nation's health and safety, and to reflect the additional resource costs incurred when procuring these domestically manufactured items. CMS is now seeking further public input on this issue, including potential policy approaches for a payment adjustment; methodology to calculated price differential between domestic and non-domestic PPE and essential medicines; information sources of those price differentials; a definition of domestic essential medicine and PPE; and a process for verifying that a given essential medicine or PPE is ''domestic.''

Additionally, CMS states it is considering sunsetting the existing surgical N95 FFRs policy, and also considering simultaneously prospectively removing the associated OPPS budget neutrality adjustment.

Medicare OPPS Drugs Acquisition Cost Survey and 340B Drugs

As required by the Social Security Act, CMS conducted a survey of acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS, including specific covered outpatient drugs (SCODs), and drugs and biologicals CMS historically treats as SCODs. The survey was administered from Jan. 1, 2026 – April 7, 2026, and captured acquisition data for drugs purchased between July 1, 2024 – June 30, 2025.

As a result, CMS found significant disparities between hospital acquisition costs for drugs acquired through the 340B program and drugs acquired outside the 340B program. Therefore, for CY 2027 and subsequent years CMS is proposing to pay for drugs acquired through the 340B program at ASP−33.4% and maintain current payment rate for drugs not acquired through the 340B program, which is generally ASP+6%. CMS estimates that the proposed policy would reduce OPPS payments by approximately $4.68 billion for CY 2027.

In alignment with historic payment policies, CMS proposes that when ASP information is unavailable, payment is based on the WAC, with WAC−33.4%. If WAC information is also unavailable CMS proposes a payment rate of 59.59% of AWP. CMS is also proposing to pay 340B drugs paid based on MUC at 100% of MUC and continue to pay for invoice priced 340B drugs at the invoice amount.

Alternatively, CMS is considering using HRSA's 340B ceiling price data rather than the survey data to calculate an average discount. Under this alternative policy, payment for 340B acquired drugs would be set at ASP−28.0%.

For CY 2027 and subsequent years CMS is proposing that rural SCHs, PPS-exempt hospitals and children's hospitals would be exempt from the 340B payment policy. CMS proposes that hospitals paid under the OPPS, other than a type of hospital excluded from the OPPS (such as CAHs or REHs) or exempted from the 340B drug payment policy for CY 2027, would be required to report modifier ''JG'' on the same claim line as the drug HCPCS code to identify a 340B-acquired drug; the modifier ''TB'' for all pass-through drugs, non-opioid treatment for pain relief drugs, and 340B-acquired drugs reported by rural SCHs, children's hospitals and PPS-exempt cancer hospitals for informational purpose; and the modifier ''XX'' for all drugs that were not acquired through the 340B Program.

Software as a Medical Service (SaMS)

In previous rulemaking, CMS has referred to the algorithm-driven services that assist practitioners in making clinical assessments or diagnoses as Software as a Service (SaaS). In other industries the SaaS terminology is used for general cloud-based computing service models outside of a health care context which may cause confusion as CMS uses it to describe services that provide medical function for the purposes of OPPS/ASC Medicare payment policy. To clarify this distinction, CMS is proposing to change the terminology from SaaS to SaMS to refer to software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality.

For CY 2027 CMS is proposing an interim payment policy for SaMS to allow for time to better understand and address the payment challenges for these technologies. CMS is also proposing to designate 36 HCPCS codes as SaMS service and to reassign those SaMS services currently paid separately under clinical APCs to new technology APCs that closely align with current CY 2026 payment rates.

Additionally, CMS proposes to create a new status indicator, "O1" (Software as a Medical Service, Paid under OPPS; separate APC payment) specifically for SaMS technologies.

Table 61 outlines the proposed new technology APC and statis indicator assignments for codes proposed to be designated as SaMS services and currently assigned to clinical APCs or not separately paid under the OPPS.

For SaMS analyses performed on laboratory tests, CMS is proposing to assign the 10 HCPCS codes listed in table 62 to new technology APCs for CY 2027. In addition, CMS also proposes to assign any new SaMS analyses performed on laboratory test codes to new technology APCs for payment under the OPPS.

RFI – Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data

In line with the Executive Order 14221, "Making America Health Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information," CMS is seeking public input on potential approaches to strengthen transparency and usability of the Machine-Readable Files (MRFs). Specifically, CMS seeks input on increasing transparency of outlier provisions, standardization to enhance MRF utility, and consumer friendly display requirements.

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