Medicare Outpatient PPS Final Rule

Calendar Year 2027 | Version 1

Overview and Resources

On November 4, 2026, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 final rule for the Medicare Outpatient Prospective Payment System (OPPS). The final 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 adopted 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;
- Updating payment rates and policies for Ambulatory Surgical Centers (ASCs).

A summary of the major hospital OPPS sections of the final rule is provided below. Adopted program changes for CY 2027 are effective on or after January 1, 2027, unless otherwise noted. CMS estimates an increase of $1.78 billion in OPPS payments for CY 2027 over CY 2026. However, for providers subject to the 340B remedy offset, CMS estimates a further $1.6 billion reduction in payments in CY 2027.

The final rule and other resources related to the OPPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

An online version of this final rule is available at https://www.federalregister.gov/d/2026-22739.

Comments are due to CMS by January 4, 2027, and can be submitted electronically at http://www.regulations.gov by using the website's search feature for "CMS-1850-FC".

Text in italics are from the November 9, 2026 *Federal Register* unless otherwise noted.

OPPS Payment Rates

Pages 70323–70328, 70332–70337, 70492–70503, and 70636–70638

CMS typically uses the most up-to-date claims data and cost report data to set OPPS rates for the upcoming year. CMS adopted 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 final CY 2027 conversion factor.

	Final CY 2026	Final CY 2027	Percent Change

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OPPS Conversion Factor	$91.415	$99.970 ($102.004 proposed)	+9.36% (11.58% proposed)
OPPS Conversion Factor with 340B Remedy Offset	$90.967	$98.011 ($99.015 proposed)	+7.74% (8.85% proposed)

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

Final CY 2027 Update Factor Component	Change to OPPS Conversion Factor
Market Basket (MB) Update	+3.2% (as proposed)
Affordable Care Act (ACA)-Mandated MB Productivity Adjustment	-0.9 percentage points (PPTs) (-0.8 PPTs proposed)
Removal of N95 Respirator BN*	+0.01% (as proposed)
Net Pass-through Spending Adjustment	+0.07% (+0.12% proposed)
Net Outlier BN	+0.00%
Wage Index BN	-0.48% (+0.98% proposed)
Wage Index 5% Stop Loss and Transitional Exception BN	-0.04% (-0.49% proposed)
COLA	-0.08% (-0.07% proposed)
Cancer Hospital BN	-0.04% (-0.06% proposed)
340B Drugs BN	+7.5% (+8.44% proposed)
Overall Final Rate Update	**+9.36% (+11.58% proposed)**
340B Remedy Offset	-1.48% (-2.93% proposed)
Overall Final Rate Update with 340B Remedy Offset	**+7.22% (+8.31% proposed)**

The adopted market basket update percentage is based on IHS Global Inc.'s second quarter 2026 forecast with historical data through first quarter 2026.

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

Pages 70492–70503

The 340B Drug Pricing Program allows certain hospitals to purchase outpatient drugs at discounted prices. From CY 2018 to September 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

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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 had proposed, but not adopted, an increase to the annual reduction for non-drug items and services from 0.49 PPT to 2.0 PPTs. CMS did state that it anticipated a larger reduction being implemented in future years. As such, beginning with CY 2027 CMS is adopting an increase to the annual reduction to the OPPS conversion factor from 0.49 PPTs to 1.96 PPTs (2.93 PPTs proposed). Under this revised rate CMS expects to recoup the $7.8 billion by the end of CY 2031.

Table 63 on page 70503 highlights the timeline for the finalized 1.96 PPTs annual reduction.

Payment Increase for Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs)

Page 70332

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

Cancer Hospital Payment Adjustment and Budget Neutrality Effect

Pages 70332–70335

CMS provides payment increases to 11 Inpatient PPS (IPPS) exempt cancer hospitals to address higher outpatient costs incurred by these hospitals. CMS achieves 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.

CMS reduces 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 adopting a target PCR of 0.88. Table 10 on page 70335 outlines the estimated percentage increase in OPPS payments for each cancer hospital for CY 2027 due to the cancer hospital payment adjustment policy.

Outlier Payments

Pages 70335–70337

To maintain total outlier payments at 1.0% of total OPPS payments, CMS is adopting an outlier fixed-dollar threshold of $7,150 ($7,100 proposed) for CY 2027, a 14.86% increase compared to the current threshold of $6,225. Outlier payments will 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.

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Cost of Living Adjustment (COLA) in Alaska and Hawaii

Pages 70636–70638

In order to account for differences in the cost of living due to location the IPPS provides COLAs for IPPS hospitals in Alaska and Hawaii. The COLA is applied by multiplying the capital rate, as well as the non-labor-related portion of the operating standardized amount, by the applicable COLA factor.

While higher labor-related costs for these states are accounted under the OPPS through the adoption of the IPPS wage index and associated wage index policies, the nonlabor portion of OPPS payment is not currently adjusted to address the higher nonlabor costs as is addressed in the IPPS through the COLA policy.

To align the IPPS and OPPS CMS is adopting to apply a COLA to the nonlabor share portion of OPPS payment in these two states. CMS is adopting the IPPS COLA factors from the FFY 2027 IPPS final rule as the CY 2027 OPPS COLA factors for hospitals located in Alaska and Hawaii.

The table below outlines the current COLA factors and the final COLA factors in the FFY 2027 IPPS final rule.

Area	Final COLA Factors FFYs 2022–2026	Final COLA Factors FFY 2027
Alaska		
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.22	1.28 (as proposed)
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.22	1.32 (as proposed)
City of Juneau and 80-kilometer (50-mile) radius by foot	1.22	1.36 (as proposed)
Rest of Alaska	1.24	1.44 (as proposed)
Hawaii		
City and County of Honolulu	1.25	1.25 (1.20 proposed)
County of Hawaii	1.22	1.32 (as proposed)
County of Kauai	1.25	1.26 (as proposed)
County of Maui and County of Kalawao	1.25	1.25 (1.24 proposed)

Wage Index and Labor-Related Share

Pages 70328–70331

As in past years, CMS will 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, due to a new hospital not having a wage index in the prior year. CMS is adopting a budget neutrality factor of 0.9996 (0.9951 proposed) for the impact of the 5% cap on wage index decreases.

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Separately, CMS is adopting a wage index and labor-related share budget neutrality factor of 0.9952 (1.0098 proposed) 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 adopting 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 will 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

Pages 70290–70321 and 70341–70423

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 adopted payment weights and rates for CY 2027 are available in Addenda A and B of the final rule at https://www.cms.gov/license/ama?file=/files/zip/2027-fr-opps-addenda.zip.

For CY 2027, CMS is adopting the recalibration of payment weights for services furnished on or after January 1, 2027, and before January 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	Final CY 2027
Pass-Through Drugs and Biologicals	G	117	88
Pass-Through Device Categories	H	19	19
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	573
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	1061

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Calculation of Cost-to-Charge Ratios (CCRs)

Pages 70290–70291

For CY 2027, CMS will continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs. CMS is also finalizing the exclusion of 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

Pages 70291–70292

Historically, CMS has made separate payments for blood and blood products through APCs rather than packaging payment for them into payments for the procedures with which they are administered. For CY 2027, CMS will continue its policy to establish payment rates for blood and blood products using a blood-specific CCR methodology.

Brachytherapy Sources

Pages 70292–70293

For CY 2027, CMS will 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 adopting to base payment rates on the geometric mean unit costs (MUCs) for each source. For CY 2027 and future years, CMS will continue 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...."*

Additionally for CY 2027, CMS will designate five brachytherapy APCs as low volume APCs.

Comprehensive APCs

Pages 70294–70308

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".

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For CY 2027 and subsequent years, CMS is continuing the exclusion of payments for cell and gene therapies from C-APC packaging, when those cell and gene therapies are not functioning as integral, ancillary supportive, dependent, or adjunctive to the primary C-APC service. A list of the cell and gene therapy services affected may be found in Table 3 on pages 70303–70304.

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 January 1, 2025 through December 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 did not propose to convert any standard APCs to C-APCs. The final CY 2027 C-APCs can be found in Table 4 on pages 70306–70308.

Composite APCs

Pages 70308–70314

Composite APCs combine payment for multiple independent services that are typically performed together during a single clinical encounter into a single OPPS payment. 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 will 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 will continue to instead be paid through composite APC 8010. In addition, CMS is adopting the continuation of 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 adopting 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 5 on pages 70311–70314 lists the HCPCS codes that are subject to the multiple imaging procedure composite APC policy, their respective families, and each family's geometric mean cost derived from CY 2025 claims data.

Universal Low Volume APC Payment Policy

Pages 70382–70383

For CY 2027, CMS will 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 final low volume APCs for CY 2027 can be found in Table 28 on page 70383.

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Payment for Medical Devices with Pass-Through Status
Pages 70423–70462

Pass-through payment facilitates access for new innovative devices by allowing adequate payment for new devices while the necessary cost data is collected to include the cost for these devices into the procedure APC rate. 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 49 on pages 70424–70425.

CMS received 19 applications for device pass-through payment applications by the March 2, 2026 deadline. CMS is adopting device pass-through payment status for seven applications that were preliminarily approved for pass-through payment status during the quarterly review process as outlined on Table 50 on page 70428.

After considering public comments, CMS is also approving device pass-through payment status for the following:

- Altius® Direct Electrical Nerve Stimulation System (pages 70428–70432)
- TIDAL™ Fusion Cage System (Ossera™ AFX) (pages 70436–70440)

Additionally, CMS is denying pass-through payment status for the following:

- ProSense® Cryoablation System (pages 70432–70436)
- EndoForce™ System (page 70440–70451)
- LINK™ External Fixator (pages 70452–70457)
- Santreva™-ATK Catheter (pages 70457–70460)

Device-Intensive Procedures
Pages 70461–70468

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

Additionally, CMS is accepting recommendations to revise the device-intensive procedure methodology to address circumstances when low volume claims may not accurately represent underlying device costs associated with a procedure. For CY 2027 and subsequent years, CMS is finalizing the device-intensive procedures proposal with a modification for device-intensive procedures with fewer than ten claims in the rate setting year, for which CMS will apply "*the greater of: (1) the device offset percentage calculated from the available claims; or (2) the device offset percentage calculated under our default methodology, which is the greater of 31 percent or the device offset percentage of the APC to which the procedure is assigned.*"

Device Edit Policy
Pages 70468–70469

CMS is adopting its proposal to continue the device edit policy for CY 2027 without modifications.

Payment Adjustment for No Cost/Full Credit and Partial Credit Devices
Pages 70469–70470

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

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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 will maintain the current no cost/full credit and partial credit device policy.

Payment for Drugs, Biologicals and Radiopharmaceuticals

Pages 70316–70321, 70470–70491, and 70557–70560

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. To provide newly approved drugs and biologicals with a pass-through payment period as close to three years as possible, CMS utilizes a quarterly expiration schedule. This policy eliminates variability in eligibility timelines while remaining within the statutory three-year limit.

For CY 2027 and subsequent years CMS is adopting the use of the existing methodology to calculate the per day costs for diagnostic radiopharmaceuticals. Consistent with methodology and practices, CMS is adopting a diagnostic radiopharmaceutical packaging threshold of $635 ($665 proposed) for CY 2027. In addition, CMS will 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 adopting a packaging threshold of $135 ($140 proposed). Drugs, biologicals, and radiopharmaceuticals (excluding diagnostic radiopharmaceuticals) that are above the $135 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 will be paid wholesale acquisition cost (WAC)+3%.

For CY 2027, CMS will 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 adopting the following as proposed:

- *"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*

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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 will continue paying for non-pass-through diagnostic radiopharmaceuticals that are separately payable. CMS is finalizing a continuation of the use of MUC data for separately payable radiopharmaceuticals due to their cost exceeding the per-day threshold.

Additionally, CMS is maintaining 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 adopting the application of this policy to diagnostic radiopharmaceuticals.

There are 49 drugs and biologicals for which pass-through payment status will expire by December 31, 2026, as listed in table 57 on pages 70471–70474. For CY 2027, CMS is ending pass-through payment status for 28 drugs and biologicals listed in Table 58 on pages 70475–70477. Additionally, CMS is continuing pass-through payment status through CY 2027 for 60 drugs and biologicals listed in Table 59 on pages 70478–70482.

Packaged Items and Services

Pages 70315–70316 and 70651–70673

CMS will 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 will 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 96 on page 70672–70673 outlines the final list of qualifying products for separate payment in the ASC setting under this policy for CY 2027.

Skin Substitutes

Pages 70552–70555

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 will 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)

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

An initial payment rate of $127.14/cm2 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. At this time CMS does not believe there is sufficient data to adopt a revised payment rate. Therefore, for CY 2027 CMS is continuing the current policy, which includes maintaining the payment rate of $127.14/cm2 for all sheet form skin substitute products for the three APCs listed above.

CMS is finalizing proposals regarding payment for non-sheet skin substitute application codes and non-sheet products with modifications. Specifically, HCPCS code G0681 is assigned to APC 5053 (Level 3 Skin Procedures) with status indicator ''T'' and G0683 to APC 5054 (Level 4 Skin Procedures APC) with status indicator ''T.'' HCPCS codes G0682 and G0684 will continue to be assigned to status indicator ''N.''

Lastly, CMS is not finalizing changes to the current payment arrangement under the OPPS for products that are not in sheet form at this time. Non-sheet skin substitute products will remain assigned to status indicator ''N.''

Other OPPS Payment Policies

Pages 70503–70505, 70560–70611, and 70639–70640

Payment for Off-Campus Outpatient Departments (OPDs)

Pages 70581–70611

In order 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 adopting the application of the MPFS equivalent payment rate 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

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- 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 8007—MRI and MRA without Contrast Composite

CMS will exempt rural SCHs from this method which aligns with the special payment treatment rural SCHs receive under the OPPS.

PHP and IOP Services

Pages 70561–70568

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 final CY 2027 PHP and IOP payment rates as found in Addendum A:

	Final Payment Rate 2026	Final Payment Rate 2027	% Change
APC 5851: Intensive Outpatient (3 services) for CMHCs	$127.74	$131.81	+3.19%
APC 5852: Intensive Outpatient (4+ services) for CMHCs	$167.38	$215.86	+28.96%
APC 5853: Partial Hospitalization (3 services) for CMHCs	$127.74	$131.81	+3.19%
APC 5854: Partial Hospitalization (4+ services) for CMHCs	$167.38	$215.86	+28.96%
APC 5861: Intensive Outpatient (3 services) for Hospital-based IOPs	$319.38	$329.53	+3.18%
APC 5862: Intensive Outpatient (4+ services) for Hospital-based IOPs	$418.45	$539.62	+28.96%
APC 5863: Partial Hospitalization (3 services) for Hospital-based PHPs	$319.38	$329.53	+3.18%
APC 5864: Partial Hospitalization (4+ services) for Hospital-based PHPs	$418.45	$539.62	+28.96%

For CY 2027, CMS is maintaining 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.

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Additionally, CMS will 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 will also maintain the CMHC outlier payment cap at 8% of the CMHC's total per diem payments and continue to include both PHP and IOP in the calculation of the CMHC outlier percentage.

Inpatient-Only List

Pages 70569–70580

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 January 1, 2029. For CY 2027, CMS will continue the second phase of elimination and remove 637 services from the IPO list. The list of procedures finalized for removal for CY 2027 is available at https://www.cms.gov/license/ama?file=/files/zip/2027-fr-procedures-removal-IPO-list.zip.

OPPS Payment Status and Comment Indicators

Pages 70639–70640

Payment status indicators are assigned to HCPCS codes and APCs to determine payment for services under the OPPS. For CY 2027 and subsequent years, CMS is adopting a revision to the current definition of "E2" status indicator to comply with the drug invoice policy. Additionally, CMS is adopting a new "01" status indicator for software as a medical service that is paid separately under the OPPS. Table 87 on page 70639 outlines the final definitions and payment status of these two status indicators. Lastly, CMS is also adopting the continued use of 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, APC assignment; comments will be accepted on the APC assignment for the new code.*

Payment for High-Cost Drugs Provided by Indian Health Service (IHS) and Tribal Facilities

Pages 70503–70505

For CY 2027, CMS will 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

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high-cost drugs furnished in IHS/tribal hospital outpatient departments that will 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 this 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 finalized list of drugs qualifying for the add-on payment and their respective payment rates for CY 2027.

Removals from the Hospital OQR and ASCQR Program Measure Sets

Pages 70680–70682

CMS is finalizing the removal of the "Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients" measure from the Hospital OQR and ASCQR programs beginning with the CY 2027 reporting period/CY 2029 payment determination.

Updates to the OQR Program

Pages 70682–70699

The OQR program is mandated by law to promote transparency and quality of care furnished at hospital outpatient departments; 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 will 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.

Table 100 on page 70697 outlines the finalized validation process for CYs 2029–2032 payment determinations.

RFI—Advanced Care Planning eCQM

Pages 70685–70688

CMS sought 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 also sought input on the relevant aspects of advanced care planning and measures appropriate for the Hospital OPD (HOPD) setting. Comments can be found on pages listed above.

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Rural Emergency Health (REH) Quality Reporting Program

Pages 70699–70700

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

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

Pages 70705–70707

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 finalizing 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 policy CMS and the Office of Inspector General retain enforcement authority.

Expansion of Botulinum Toxin Injection Codes for HOPD Prior Authorization Process

Pages 70707–70715

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 adopting to add prior authorization requirements for eight additional botulinum toxin injection codes listed on Table 102 on page 70712.

The full list of outpatient services that currently require prior authorization may be found in Table 103 on pages 70713–70715.

Requirements for Provider-Based Status

Pages 70715–70724

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.

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As such, CMS is finalizing 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 finalized 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 January 1, 2028, an initial attestation must be submitted between January 1, 2026 and December 31, 2027. For off-campus outpatient departments that begin providing services after January 1, 2028 an attestation must be submitted within the 2 years prior to when the billed services are delivered.

Additionally, CMS is adopting a standardized attestation form for provider-based determinations that will replace the current Medicare Administrative Contractor (MAC) specific templates. Under this, main providers will submit the attestation through a centralized electronic system. CMS also adopted a modification to 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 contractor, 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. Specific documentation framework is outlined on pages 70723–70724.

Graduate Medical Education (GME)

Pages 70724–70725

CMS is providing public notification of the closure of two teaching hospitals 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)
260176	St. Luke's Des Peres Hospital	Des Peres, MO	41180	July 31, 2025	25.16	26.06
150004	Franciscan Health Hammond	Hammond, IN	29414	December 31, 2022	4.39	4.36

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

Page 70726

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

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and safety, and to reflect the additional resource costs incurred when procuring these domestically manufactured items. In the CY 2027 OPPS Proposed Rule CMS sought 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.''

CMS will consider public comments received on this topic for future rulemaking.

Medicare OPPS Drugs Acquisition Cost Survey and 340B Drugs

Pages 70505–70552

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 January 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 will pay for drugs acquired through the 340B program at ASP−28.0% (ASP−33.4% proposed) and maintain current payment rate for drugs not acquired through the 340B program at a rate of ASP+6%. CMS estimates that this policy will reduce OPPS payments by approximately $4.65 billion ($4.68 billion proposed) for CY 2027.

In alignment with historic payment policies, CMS finalized that when ASP information is unavailable, payment is based on the WAC, with WAC−28.0% (WAC−33.4% proposed). CMS is adopting a payment rate of 64.53% of AWP (59.59% proposed) when WAC information is also unavailable. CMS is also adopting its proposal 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.

For CY 2027 and subsequent years CMS is adopting that rural SCHs, PPS-exempt cancer hospitals and children's hospitals will be exempt from the 340B payment policy. CMS states 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)

Pages 70611–70636

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 adopting the terminology change 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.

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CMS is also designating 36 HCPCS codes as SaMS service and reassigning those SaMS services currently paid separately under clinical APCs to new technology APCs that closely align with current CY 2026 payment rates.

Additionally, CMS adopted the creation of a new status indicator, "01" (Software as a Medical Service, Paid under OPPS; separate APC payment) specifically for SaMS technologies.

Table 84 on pages 70622–70627 outlines the proposed, requested and final new technology APC and status indicator assignments for codes finalized 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 adopting 14 (10 proposed) HCPCS codes listed in table 85 on page 70634–70635 to new technology APCs for CY 2027. In addition, CMS adopted 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

Page 70726

In line with the Executive Order 14221 (90 FR 11005), "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information," CMS sought public input on potential approaches to strengthen transparency and usability of the Machine-Readable Files (MRFs). Specifically, CMS sought input on increasing transparency of outlier provisions, standardization to enhance MRF utility, and consumer friendly display requirements.

CMS will consider public comments received on this topic for future rulemaking.

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