Final 2027 Hospital Outpatient and Ambulatory Surgical Center Payment Rule Released

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems. The rule was mostly finalized as proposed, with a few notable exceptions, including a smaller reduction in 340B drug payment than CMS proposed. The rule takes effect January 1, 2027, except where otherwise noted.

2027 OPPS and ASC Payment Updates

CMS finalized a 2.3 percent update for both hospital outpatient departments (HOPDs) and ASCs, compared with 2.4 percent in the proposed rule, as outlined below:

	OPPS	ASC
2027 payment update	2.3%	2.3%
Estimated 2027 total payments	$114.4 billion	$9.9 billion
Increase from 2026	$11 billion	$560 million

These updates reflect:

- A 3.2 percent hospital market basket increase
- A 0.9 percentage point productivity adjustment

This increase reflects a built-in feature of hospital payment: each year, Medicare automatically raises hospital and ASC rates to keep pace with the rising cost of running a facility. Physicians have no such automatic adjustment. Under the 2027 Medicare Physician Fee Schedule (MPFS) final rule, physicians face a net payment cut in 2027, even as hospitals and ASCs receive an increase. Over time, that disparity compounds: between 2001 and 2025, Medicare hospital updates totaled approximately 80 percent, while Medicare physician pay increased only 7 percent. This imbalance threatens the financial stability of physician practices and patients' access to care, particularly in small, independent, and rural practices. The American Medical Association (AMA) continues to advocate for an annual physician payment update tied to the Medicare Economic Index (MEI), which measures growth in the cost of running a medical practice, and strongly supports the bipartisan Patients First Act (H.R. 9693), which would establish one. The AMA is urging Congress to act before the physician payment cuts take effect on January 1 and will continue to press lawmakers during the lame-duck session.

Site-Neutral Payment for Imaging Without Contrast

Despite AMA opposition, CMS finalized its proposal to pay for imaging services without contrast furnished in excepted (grandfathered) off-campus HOPDs at the MPFS-equivalent rate of 40 percent of the OPPS rate. Beginning January 1, 2027, the policy applies to the 337 services in the four imaging without contrast ambulatory payment classifications (APCs), as well as the three multiple imaging composite APCs. CMS finalized the policy outside of budget neutrality, removing an estimated $260 million from Medicare in 2027 ($190 million in

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Medicare spending and $70 million in beneficiary cost sharing). As the AMA supported, off-campus departments of rural sole community hospitals are exempt.

The AMA supports site-neutral payment in principle but does not believe it should be achieved by removing dollars from the Medicare program. In its comments, the AMA urged CMS to reinvest the savings in other Part B services, including the MPFS; to evaluate the drug administration site-neutral policy it finalized last year before expanding further; and to target any reductions to the codes that account for more than 95 percent of the affected volume. The AMA continues to advocate that if CMS pursues site-neutral payment policies, the resulting savings should be redirected within Part B, including to physician payment updates that keep independent practices viable, rather than removed from the program altogether.

Inpatient Only (IPO) List

CMS finalized its proposal to remove 637 services across 11 clinical families from the IPO list beginning January 1, 2027. This is the second year of the three-year elimination of the IPO list that CMS finalized last year. The remaining services, including cardiovascular, neurological, and transplant procedures, are scheduled for removal in 2028. Services removed from the list remain payable in the inpatient setting when the physician determines that a patient needs inpatient care.

The AMA supports removing services from the IPO list where evidence shows they can be furnished safely in the outpatient setting for Medicare patients. However, the AMA urged CMS to hold each phase to the same evidentiary standard it applied last year, developed with the relevant national medical specialty societies, and to let clinical and payment system readiness, rather than a fixed calendar, set the pace. CMS said Medicare Advantage issues are outside the scope of this rule but reiterated that Medicare Advantage plans must follow the two-midnight benchmark for inpatient admissions.

340B Drug Payment

CMS finalized a reduction in payment for drugs acquired through the 340B program, from average sales price (ASP) plus six percent to ASP minus 28 percent, beginning January 1, 2027. CMS had proposed ASP minus 33.4 percent, based on its drug acquisition cost survey. It finalized the smaller reduction based on 340B ceiling price data, which the survey validated, stating that this responds to commenters' concerns that the proposed rate would be too steep a cut and could limit patient access to these drugs. However, CMS stated that if a court were to find it lacks authority to set the rate using ceiling price data, it would consider ASP minus 33.4 percent a more accurate measure of hospital acquisition costs than the prior rate of ASP plus 6 percent. The policy also applies to drugs furnished in nonexcepted off-campus provider-based departments. CMS estimates the policy will reduce Original Medicare drug payments by approximately $4.35 billion and beneficiary copayments for drugs by $1.1 billion in 2027. Because the statute requires the change to be budget neutral, CMS will raise OPPS payments for other services by an estimated 7.5 percent. Separately, CMS increased the annual payment reduction that recovers the remedy for its 2018–2022 340B policy from 0.5 percent to two percent, rather than the proposed three percent. This will reduce payment for non-drug services by an estimated $1.6 billion in 2027 at hospitals enrolled in Medicare before 2018, with the full amount recovered by 2031.

Prior Authorization for Botulinum Toxin Injections

Despite AMA concerns, CMS finalized its proposal to add eight botulinum toxin injection codes to the HOPD prior authorization program beginning July 1, 2027. The AMA urged CMS not to finalize the policy without first examining growth by service and clinical indication, including new Food and Drug Administration (FDA)-approved uses. CMS also did not adopt the safeguards the AMA requested: a single approval covering at least 12 months of recurring therapy, and decisions within 72 hours for standard requests and 24 hours for expedited

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requests, consistent with the standards CMS applies to Medicare Advantage. The AMA will continue to press for these safeguards, because expanding prior authorization without them will impose unnecessary administrative burdens, delay medically necessary care, and create avoidable barriers for patients receiving ongoing treatment.

Software as a Medical Service (SaMS)

CMS finalized its proposal to replace the term "Software as a Service" with SaMS, to assign 30 designated SaMS codes to New Technology APCs as an interim payment approach for 2027, and to create a new status indicator "O1" for these services. The AMA supported this approach, provided that SaMS functions as an interim Medicare payment designation rather than a coding system that competes with the Current Procedural Terminology (CPT) code set. Over AMA objections, CMS also moved 14 codes describing SaMS analyses of laboratory tests from the Clinical Laboratory Fee Schedule to New Technology APCs under the OPPS. In response to commenter feedback, CMS revised the code list, removing some proposed codes and adding others, for a total of 14 codes compared with 10 proposed. The AMA had urged CMS to withdraw the list pending a code-by-code technical review with the relevant stakeholders.

Skin Substitutes

As the AMA supported, CMS finalized its proposal to keep the 2026 skin substitute framework unchanged for 2027, including a single payment rate of $127.14 per square centimeter for all sheet-form products, while a full year of claims data is collected. The AMA urged CMS to monitor patient access, particularly for complex, non-healing wounds, and to keep OPPS and MPFS rates aligned.

Provider-Based Status Attestation

CMS finalized regulations implementing section 6225 of the Consolidated Appropriations Act, 2026. Beginning January 1, 2028, Medicare will pay an off-campus HOPD only if it bills under its own National Provider Identifier (NPI) and the hospital has submitted a provider-based attestation for that department within the prior two years, using a new standardized form submitted through a centralized electronic system. The AMA supported these requirements because knowing which locations charge facility fees is a precondition for telling patients what they will pay. CMS did not adopt the formal cure period commenters requested for attestation errors, but said hospitals with minor deficiencies may be given an informal opportunity to correct them before CMS issues a determination.

ASC Payments

CMS extended for one more year, through 2027, its use of the hospital market basket rather than the Consumer Price Index for All Urban Consumers (CPI-U) to update ASC payments. The AMA supports this policy because it reduces long-standing payment disparities between ASCs and HOPDs and encourages migration of appropriate cases to lower-cost settings. CMS also finalized adding 618 procedures to the ASC covered procedures list, nearly all of them services removed from the IPO list for 2027.

Despite AMA advocacy, CMS will continue to apply the ASC weight scalar, which reduces ASC payment rates to maintain budget neutrality separately from the OPPS. Largely because of the 340B policy, the scalar will fall to 0.814 from 0.872 in 2026, lowering ASC payment in 2027 for some ophthalmic, interventional pain, and dialysis vascular access procedures even as overall ASC rates rise. CMS also did not extend hospital geographic reclassification and wage index floor policies to ASCs, stating that the statute's reclassification provision applies only to acute care hospitals. CMS said it will monitor wage index differences between the two payment systems and may revisit the issue in future rulemaking. The AMA will continue to urge CMS to discontinue the scalar or, as an alternative, combine OPPS and ASC utilization into a single budget neutrality calculation.

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Hospital Price Transparency Request for Information

CMS included a request for information (RFI) on strengthening the standardization and comparability of hospital price transparency data. In its comments, the AMA urged CMS to make hospital prices comparable across the settings where a service may be furnished, including physician offices and ASCs. The AMA also asked CMS to require clear disclosure of whether a price reflects facility charges, professional charges, or both, and not to extend price-posting mandates to physician practices. In the final rule, CMS said it received 185 comments on the RFI and will consider them in future rulemaking.

Additional Resources:

- Final rule text
- CMS Press Release
- OPPS/ASC Fact Sheet

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