Key Provisions in Medicare's 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule [CMS-1850-FC]

Final Rule Summary

- **Payment update:** CMS finalized the hospital market basket update for ASCs for CY 2027, with a 2.3 percent conversion factor increase. Final conversion factors: $57.721 for ASCs and $99.970 for HOPDs.
- **Weight scalar:** The ASC weight scalar is 0.814, down from 0.872 in 2026. CMS retained its policy of excluding device portions from the weight scalar calculations.
- **Procedures and complexity adjustments:** CMS finalized 618 additions to the ASC covered procedures list, removal of 637 codes from the inpatient-only list, and 47 complexity adjustment code combinations.
- **Quality reporting:** ASC-9 will be removed beginning with the CY 2027 reporting period/CY 2029 payment determination. CMS will consider comments on potential future stratification of the All-Cause Hospital Transfer/Admission measure.
- **ASC payment estimate:** Total CY 2027 ASC payments are estimated at $9.9 billion, approximately $560 million above CY 2026.

PROPOSED RULE	ASCA COMMENTS	FINAL RULE
Updating the ASC Conversion Factor (Starts on page 533 of 723) • CMS proposed to update the ASC conversion factor using the hospital market basket (HMB) (together with the multi-factor productivity (MPF) adjustment) through 2027. ***The initial five-year trial was 2019-2023, was extended through 2025, and then through 2026. In the 2027 proposed rule, CMS stated, "for this proposed rule, we propose to extend our utilization of the hospital market basket update factor in the ASC payment system for one additional year, through CY 2027, as we continue to review and evaluate hospital***	• Thanked CMS for listening to our request to continue to use the HMB to update ASC reimbursement rates. • Expressed disappointment that this change was not made permanent or extended for greater than a year, citing KNG study proving increased savings during the trial period: (https://www.ascassociation.org/asca/about-ascs/savings/medicare-	**Updating the ASC Conversion Factor (Starts on page 1039 of 1270** • CMS finalized its proposal to apply the HMB update to the ASC payment system for CY 2027. • CMS referenced comments that opposed the extension, stating that hospitals and ASCs have different cost structures and patient populations and that the hospital market basket does not accurately measure ASC input costs. These commenters recommended that CMS collect minimally burdensome ASC cost data and develop an ASC-specific market basket. CMS indicated that they did not propose to collect ASC-specific cost data in the CY 2027 OPPS/ASC proposed rule. ASCs currently

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outpatient and ASC utilization data, as well as the migration of surgical procedures between settings." • For CY 2027, the conversion factor is proposed to be increased by 2.4 percent under the OPPS and ASC Payment System (for facilities that meet the quality reporting requirements) (calculated as 3.2 percent HMB update minus the MFP of 0.8 percent). The proposed conversion factor is **$57.766** for ASCs and **$102.004** for HOPDs. While the conversion factor is an increase from that in the 2026 final rule ($56.32), the ratio of these conversion factors is 56.63 percent, which is much lower than the ratio in 2026 (61.61 percent), leading to a growing disparity in reimbursement between ASCs and HOPDs.	savings-from-use-of-ambulatory-surgery-centers). • Discussed inflation and the increasing costs (including anesthesia stipends and staffing costs) that far exceed the HMB. • Transitioned to how the impact of the weight scalar not only neutralizes any increase, but results in a decrease in reimbursement for the vast majority of our highest-volume codes.	do not submit cost reports, so CMS is unable to discern if there is a meaningful difference in the cost structures between the hospital and ASC setting and if such differences would necessitate a different update factor. • For CY 2027, the final conversion factor is increased by 2.3 percent under the OPPS and ASC payment systems (calculated as 3.2 percent HMB minus the MFP of 0.9 percent). The final conversion factor is **$57.721** for ASCs and **$99.970** for HOPDs. These are both lower than the proposed rates. In addition, while the ASC conversion factor is higher than in 2026, the ratio of these conversion factors is 57.7, which is much lower than the ratio in 2026 (61.61 percent), leading to a growing disparity in reimbursement between ASCs and HOPDs.
Updating the ASC Relative Payment Weights for CY 2027 (Starts on page 529 of 723) • CMS proposed an ASC weight scaler of **0.809**, which is a substantial decrease from the 2026 final weight scaler of 0.872. • OPPS weight scaler was proposed to be 1.4582. • CMS explained that device portions of device-intensive (DI) procedures are not scaled so that payment for device portions remain constant between the OPPS and ASC payment system.	• ASCA again adamantly requested that CMS discontinue use of the ASC weight scaler, as continuing the scaler is counter to the Agency's stated interests in moving volume to the ASC. • Absent that, ASCA requested a unified weight scalar (one scaling performed using	**Updating the ASC Relative Payment Weights for CY 2027 (Starts on page 1032 of 1270)** • CMS finalized an ASC weight scalar of **0.814**. Although a small increase from the proposed weight scalar of 0.809, it is still a substantial decrease from the 2026 final weight scalar of 0.872. • The OPPS final weight scalar is 1.4614, an increase from the proposed weight scalar of 1.4582.

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However, due to increased utilization of orthopedic procedures in the ASC setting, ASC expenditures on device portions of DI procedures represent a substantially larger share of total ASC expenditures than in prior years. • CMS estimated that spending attributable to device portions increased from approximately 5.4 percent of total ASC expenditures in CY 2016 to roughly 32.4 percent of total ASC expenditures in 2026. • CMS asserted the weight scaler reduction is largely attributable to the substantial increase in expenditures for device portions of DI procedures under the ASC payment system. • CMS solicited comment on whether the device portions of DI procedures calculated using the OPPS conversion factor should continue to be excluded from the ASC weight scaler, or alternatively, whether these device portions should be included in the expenditures subject to scaling through the ASC weight scaler. • CMS estimated that treating device expenditures for DI codes as scalable prospective expenditures would increase the proposed ASC weight scaler from **0.809** to **0.865** in CY 2027 and would reduce the device portions of device intensive procedures by approximately 14 percent.	HOPD and ASC volume data at the same time). • We highlighted the KNG cost savings research and provided analysis showing shifting volume to the ASC setting saves Medicare money. • Alternatively, policies that stifle this migration will result in reduced savings. • ASCA did not take a position as to whether the agency should continue to exclude device portions of DI procedures from the ASC weight scaler or include device portions in the expenditures subject to scaling through the ASC weight scaler. • Both options are bad, and we did not want to set the precedent that CMS apply the weight scalar to device costs moving forward.	• CMS declined to change its policy of excluding devices from the weight scalar calculations.

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Proposed Additions to the List of ASC Covered Surgical Procedures (Starts on page 508 of 723) • CMS proposed adding 618 codes to the ASC-CPL in 2027. • Many of these codes, including all four of the hernia codes ASCA requested for inclusion, are procedures that were also proposed for removal from the inpatient-only (IPO) list for 2027. CMS proposed the removal of 637 procedures from the IPO list in 2027, continuing its three-year transition to phase out the IPO list entirely.	• ASCA supported the changes proposed for the ASC covered procedures list (ASC-CPL) and encouraged further policy changes to ensure that the appropriate site of care is determined by healthcare providers. • ASCA requested that CMS remove the restriction that prohibits ASCs from billing Medicare for unlisted codes. • ASCA highlighted the reimbursement disparities that may hinder migration of codes even if they are clinically safe for the ASC setting.	**Final Additions to the List of ASC Covered Surgical Procedures (Starts on page 992 of 1270)** • CMS finalized the addition of the same 618 codes included in the proposed rule, including the hernia codes requested by ASCA. • The list of codes finalized for addition to the ASC-CPL in 2027 can be found on ASCA's Medicare Resources Page.
Proposed Elimination of the Inpatient-Only List (IPO-list) (Starts on page 413 of 723) • CMS proposed to eliminate 637 of the remaining 1,438 codes on the IPO list. • This is the continuation of a policy CMS finalized in 2026 to eliminate the IPO list	• ASCA supported CMS allowing discretion to clinical decision-making. However, our comments noted there might be certain unintended consequences of removing the IPO list entirely.	**Final CY 2027 Changes to IPO List (Starts on page 749 of 1270)** • CMS finalized the same 637 codes that had been proposed for removal from the IPO list. • That list is available here: 2027 FR Procedures for Removal from IPO List

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through a 3-year transition. In 2026, the codes removed from the IPO list were musculoskeletal. • For CY 2027, the codes proposed for removal from the IPO list fall within the following clinical families: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary. • If CMS finalizes its proposal to remove these services for CY 2027, the majority of remaining services are more complicated in nature and may require a lengthier review process and potential changes to current APCs in order to determine an appropriate APC assignment. For example, some of the remaining procedures for removal in CY 2028 would be from the neurological family, cardiovascular family, solid organ, intestinal, and islet cell transplants and related services.	• The complete elimination of the IPO list means that every code must be assigned to an ambulatory payment classification (APC) group, regardless of whether there will be any volume in the outpatient setting. ASCA is concerned that even projecting a small amount of volume for procedures that will not actually be performed in our setting will negatively impact procedures currently on the ASC-CPL.	• CMS stated that they "continue to believe that there are a number of safety mechanisms that will continue to ensure the safety of our beneficiaries and the quality of care, including physician judgment, State and local regulations, accreditation requirements, medical malpractice laws, hospital conditions of participation, and other CMS initiatives."
Proposed Payment for ASC Add-On Procedures Eligible for Complexity Adjustments under the OPPS (Starts on page 487 of 723) • For 2027, CMS identified **41** different complexity adjustment code combinations for codes that are payable in the ASC setting and would be eligible for a complexity adjustment if the procedure were performed in an HOPD. This	• ASCA commented in support of further evaluation of this policy to ensure all appropriate code combinations are contemplated. • We understand that claims may be denied by Medicare	**Final Payment for ASC Add-On Procedures Eligible for Complexity Adjustments under the OPPS (Starts on page 953 of 1270)** • CMS finalized **47** different complexity adjustment code combinations for codes that are payable in the ASC setting and would be eligible for a complexity adjustment if the procedure were performed in an

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is down from **45** in 2025 and 2026, 47 in 2024 and 55 in 2023. • Background: In 2023, CMS finalized a policy to provide increased payment to ASCs for combinations of certain service codes and add-on procedure codes that are eligible for a complexity adjustment under the OPPS because while add-on codes (N1) do not come with additional reimbursement (packaged into primary code), the addition of the add-on codes to a primary procedure code often changes the complexity of the procedure, making it more costly to perform.	Administrative Contractors (MAC) when N1 codes appear with the primary code, even though the primary code is payable. CMS must clarify in the billing claims processing manual that the entire claim will not be denied by the MACs when an add-on code is billed that may not be deemed payable.	HOPD. This is up from 45 in 2025 and 2026, and the same number that existed in 2024.
Proposed Measure Removal for the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs (Starts on page 539 of 723) • CMS proposed to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (the Colonoscopy Follow-Up Interval) measure (ASC-9 in the ASC Quality Reporting (ASCQR) Program), beginning with the CY 2027 reporting period/CY 2029 payment determination. • This measure was adopted in the CY 2014 OPPS/ASC final rule to assesses whether the recommended 10-year interval for a follow-up	• ASCA supported the removal of this measure from the ASCQR Program. • ASCA echoed the ASC Quality Collaboration's comments regarding this measure removal in addition to other concerns regarding the ASCQR program.	**Measure Removal for the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs (Starts on page 1047 of 1270)** • CMS finalized its proposal to remove *ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients* beginning with the CY 2027 reporting period/CY 2029 payment determination.

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colonoscopy is documented in the colonoscopy report, rather than whether appropriate clinical care is delivered. • CMS notes that the HOQR and ASCQR Program measure sets both currently include another measure tied more closely to outcomes of continued interest and importance—the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure, which assesses the incidence of hospital returns within 7 days of a colonoscopy, including emergency department visits, observation stays, and unplanned readmissions.		
Request for Information on Stratification of the All-Cause Transfer/Admission Measure (Starts on page 569 of 723) • Currently, the measure does not distinguish the phase of care in which a transfer occurs (pre-procedure, intra-procedure, or post-procedure). • CMS is considering whether adding a phase of care stratification relative to the surgical encounter (for example, pre-procedure, intra-procedure, and post-procedure) could improve the interpretability and usefulness of the All-Cause Transfer/Admission measure in the ASC	• ASCA did not support stratification of *ASC-4: All-Cause Hospital Transfer/Admission* at this time. • Keeping in mind that CMS appears to be planning to retain all phases of care in the measure, we question whether the new burdens that would be imposed by stratification of measure data	**Request for Information on Stratification of the All-Cause Hospital Transfer/Admission Measure (Starts on page 1104 of 1270)** • CMS stated that it appreciated all the comments on this topic. While they are not responding to specific comments in response to the RFI in this final rule, they believe that this input is very valuable and will continue to take such comments into account for a potential future stratification of the All-Cause Hospital Transfer/Admission measure that may be proposed in future rulemaking.

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Quality Reporting Program. Stratification by phase of care would improve attribution and interpretability across the diverse range of ASC services, including non-operative procedures such as those associated with pain management, for hospital transfers/admissions associated with ASC care. • CMS sought public comments on clinically meaningful and operationally feasible approaches for incorporating a phase of care stratification for the All-Cause Transfer/Admission measure. CMS requested feedback on potential stratification frameworks, "including appropriate time anchors, their operational definitions, and the corresponding time windows that could be used to define each stratification category."	by phase-of-care based approach would add information that is sufficiently useful and valuable to warrant the additional effort involved. • ASCA's comments were aligned with the ASCQC's comments. The ASCQC continues to evaluate this measure and its potential stratification.	
Overall Impact of Provisions of this Proposed Rule (Starts on page 669 of 723) • CMS estimates that the total increase in Federal Government expenditure under the OPPS for CY 2027, compared to CY 2026, due to the changes to the OPPS in this proposed rule, will be approximately **$1.82** billion.	• According to the KNG study, ASCs save the Medicare program more than $5 billion annually (with the potential for even greater savings in the future). • These savings represent more than half the increase in	**Overall Impact of Provisions of this Final Rule with Comment Period (Starts on page 1207 of 1270)** • CMS estimate that the total increase in Federal Government expenditures under the OPPS for CY 2027, compared to CY 2026, due to the changes to the OPPS in this final rule with comment period, will be approximately **$1.78 billion**.

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• Taking into account estimated changes in enrollment, utilization, and case-mix for CY 2027, CMS estimates that the OPPS expenditures, including beneficiary cost-sharing, for CY 2027 will be approximately **$110.9** billion, which is approximately **$9.5** billion higher than estimated OPPS expenditures in CY 2026. • CMS estimates the total increase (from changes to the ASC provisions in this proposed rule, as well as from enrollment, utilization, and case-mix changes) in Medicare expenditures (not including beneficiary cost-sharing) under the ASC payment system for CY 2027 compared to CY 2026, to be approximately **$520** million. The total for ASC expenditures in 2027 is estimated at **$9.9** billion. Tables 89 and 90 of this proposed rule display the redistributive impact of the CY 2027 changes regarding ASC payments, grouped by specialty area and then grouped by procedures with the greatest ASC expenditures, respectively.	OPPS expenditures that CMS forecasts. • CMS should pursue policies that encourage – not stifle – the migration of services, in order to ensure ASCs are able to continue saving the Medicare program and its beneficiaries billions of dollars annually.	• Taking into account estimated changes in enrollment, utilization, and case-mix for CY 2027, CMS estimates that the OPPS expenditures, including beneficiary cost-sharing, for CY 2027 will be approximately **$114.4 billion**, which is approximately **$10.7 billion** higher than estimated OPPS expenditures in CY 2026. These estimates are higher than those in the proposed rule. • Based on this update, CMS estimates that total payments to ASCs (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2027 will be approximately **$9.9 billion**, an increase of approximately **$560 million** compared to estimated CY 2026 Medicare payments. • According to these projections, ASCs would represent approximately 8% of the spend between HOPDs and ASCs in 2027.