AANS/CNS
Washington Committee

CY 2027 Medicare Hospital Outpatient Prospective Payment System and the Medicare Ambulatory Surgical Center Payment System Final Rule [CMS-1850-FC] Summary and Analysis

EXECUTIVE SUMMARY

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the calendar year (CY) 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) Payment System final rule [CMS-1850-FC], which updates Medicare payment rates and quality reporting requirements for hospital outpatient departments (HOPDs) and ASCs.

For CY 2027, CMS estimates that the combined effect of finalized policies will **increase overall OPPS payments by approximately 1.7%** compared with CY 2026. **However, the impact varies considerably by hospital type and payment policy.** In particular, changes to 340B drug reimbursement and the associated budget-neutrality adjustments will redistribute payments between drug and non-drug services and among hospitals.

Several provisions have implications for neurosurgical services, particularly the continued expansion of outpatient surgical options, payment for neuromodulation and emerging technologies, and policies affecting access to hospital-based imaging and procedures.

Key provisions affecting neurosurgery and hospital outpatient services include the following:

- **OPPS Payment Update:** CMS finalized a 2.3% increase to OPPS payment rates, based on a 3.2% hospital market basket update reduced by a 0.9 percentage point productivity adjustment. Although the Agency projects an overall 1.7% increase in OPPS payments, the impact varies by hospital type, including an estimated 2.7% reduction for major teaching hospitals.

- **340B Drug Payment Policy:** CMS finalized payment for 340B-acquired drugs at average sales price (ASP) minus 28%, based on a new hospital drug acquisition cost survey. To maintain budget neutrality, CMS will increase payments for non-drug services by an estimated 7.5%. Separately, CMS accelerated the prospective offset for prior 340B-related overpayments, increasing the annual reduction to non-drug payment rates from 0.5% to 2% for affected hospitals.

- **Off-Campus Hospital Imaging:** CMS expanded its policy to control outpatient service volume by applying the Medicare Physician Fee Schedule (MPFS)-equivalent payment rate to imaging without contrast services furnished in excepted off-campus provider-based departments (PBDs). The policy includes certain CT scans and MRIs and is expected to reduce Medicare Part B expenditures by approximately $260 million in its first year.

- **Inpatient Only List:** CMS finalized the removal of 637 additional procedures from the IPO list as part of its three-year phase-out. The neurological, cardiovascular, and transplant clinical families remain deferred until CY 2028. This provides an additional opportunity for specialty-specific review of complex neurosurgical procedures before any transition to outpatient payment.

- **ASC Covered Procedures List:** CMS finalized the addition of 618 procedures to the ASC Covered Procedures List (CPL), corresponding to procedures removed from the IPO list for CY 2027, as well as one additional procedure. CMS maintained its position that inclusion on the ASC CPL does not establish that an ASC is the appropriate setting for an individual patient and that site-of-service decisions remain subject to physician clinical judgment.

- **Prior Authorization:** CMS declined to rescind its use of prior authorization for neurosurgical procedures, including cervical fusion with disc removal (CPT codes 22551 and 22552) and implanted spinal neurostimulators (CPT code 63650), in place since 2021.

- **Hospital Outpatient Quality Reporting:** CMS finalized changes to the validation of electronic clinical quality measure (eCQM) data and removed the Appropriate Follow-Up Interval for Normal Colonoscopy measure. CMS did not adopt the proposed Advance Care Planning eCQM for the Hospital Outpatient Quality Reporting Program but will continue considering potential approaches to outpatient advance care planning measurement.

- **ASC Quality Reporting:** CMS removed the colonoscopy follow-up measure from the ASC Quality Reporting Program and did not finalize changes to the All-Cause Hospital Transfer/Admission measure. CMS continues to consider stratifying transfers by phase of care, provided medically appropriate transfers are not treated as quality failures.

On September 14, 2026, the AANS/CNS submitted comments to CMS on the proposed rule, emphasizing the importance of preserving patient safety, physician-led clinical decision-making, adequate reimbursement, and access to medically necessary care across various OPPS and ASC payment and quality reporting provisions.

The comment letter is available on the AANS website and the CNS website.

The following sections provide additional details on the final rule's payment and quality provisions and their implications for neurosurgery.

PAYMENT UPDATES AND POLICIES

Medicare hospital outpatient payment continues to evolve as CMS pursues changes intended to expand outpatient surgical options, reduce differences in payment across care settings, and align reimbursement more closely with hospital costs. These policies have important implications for hospitals furnishing complex surgical and diagnostic services, including neurosurgical procedures that require specialized resources, technology, and postoperative capabilities.

Although the CY 2027 OPPS final rule includes some payment increases and expanded opportunities for outpatient care, several finalized policies will redistribute reimbursement among hospitals and services. The continued expansion of outpatient payment eligibility also raises questions about whether existing payment classifications adequately reflect the clinical complexity and resources required for certain procedures.

2027 OPPS Payment Impacts

For CY 2027, CMS finalized a 2.3% increase to OPPS payment rates for hospitals meeting applicable quality

reporting requirements. The increase reflects a projected hospital market basket update of 3.2%, reduced by a 0.9 percentage point productivity adjustment.

The Agency estimates that total OPPS payments, including beneficiary cost sharing, will increase by approximately $1.78 billion compared with CY 2026, reflecting the finalized payment updates and changes in utilization and other payment policies. However, the combined effect of all finalized policies produces an estimated 1.7% increase in overall OPPS payments. This estimate reflects the OPPS update, changes in estimated outlier payments, the payment adjustment for off-campus imaging without contrast services, and other policy changes.

As shown in Table 1, the payment impact varies substantially across hospital types.

Table 1: CY 2027 OPPS Payment Impact by Hospital Type

Hospital Type	Estimated CY 2027 Payment Impact
All OPPS Facilities	+1.7%
Urban Hospitals	+1.3%
Rural Hospitals	+5.3%
Major Teaching Hospitals	-2.7%
Minor Teaching Hospitals	+2.8%
Nonteaching Hospitals	+6.0%
Voluntary Hospitals	+1.4%
Proprietary Hospitals	+10.1%
Governmental Hospitals	-1.7%

Hospitals subject to the 340B remedy offset will experience an additional 2 percentage point reduction in payments for non-drug services.

These estimates demonstrate that the overall OPPS update does not result in uniform payment increases across hospitals. The net impact varies based on hospital characteristics, service mix, wage adjustments, and exposure to specific payment policies.

Neurosurgery is particularly affected by these changes because HOPDs provide a range of specialized diagnostic, interventional, and surgical services. Payment reductions and changes in APC assignments may affect hospitals' ability to sustain these services, particularly when reimbursement does not adequately account for the specialized equipment, personnel, and technology required to deliver neurosurgical care.

340B Drug Payment Policy

In the proposed rule, CMS sought to revise payment for drugs acquired through the 340B Drug Pricing Program based on a new hospital drug acquisition cost survey. The Agency also proposed changes to the prospective offset used to recoup additional payments made to hospitals for non-drug services between CY 2018 and CY 2022 under the prior 340B payment policy.

CMS finalized most of its proposed changes to the 340B Drug Pricing Program, with two notable modifications: a less substantial reduction in payment for 340B-acquired drugs and a smaller budget neutrality increase to payments for other OPPS items and services.

340B Drug Payment Reduction

CMS finalized a reduction in Medicare payment for separately payable 340B-acquired drugs from ASP plus 6% to ASP minus 28%, compared with the proposed ASP minus 33.4%. Drugs acquired outside the 340B program will continue to be paid at ASP plus 6%. The Agency also finalized its proposal not to provide a separate payment for the overhead and handling costs associated with 340B drugs. The reduction does not apply to specified hospitals, including children's hospitals, rural sole community hospitals, critical access hospitals, and Indian Health Service hospitals, or to certain drugs, including vaccines, pass-through drugs, and qualifying non-opioid pain management drugs. The reduction also applies to drugs furnished in non-excepted off-campus provider-based departments, which are otherwise paid at 40% of OPPS rates.

Budget Neutrality

Because the finalized payment reduction is smaller than proposed, CMS also reduced the corresponding budget-neutrality adjustment for other OPPS services. The Agency estimates that payments for 340B drugs will decrease by approximately $4.65 billion in CY 2027, compared with $4.85 billion under the proposed rule. To maintain budget neutrality, CMS finalized a 7.5% increase in payments for other OPPS items and services, compared with the proposed 8.44% increase. This adjustment applies to all OPPS hospitals, including those that do not participate in the 340B program.

340B Remedy Offset

CMS finalized an increase in the reduction to non-drug OPPS payments from 0.5% to 2% to recoup approximately $7.8 billion in additional non-drug payments hospitals received between CY 2018 and CY 2022 under the prior 340B payment policy. The Agency estimates that the increased offset will allow full recovery by CY 2031.

340B Reporting Modifiers

Beginning January 1, 2027, hospitals must use new modifiers to identify drugs based on their acquisition status. Modifier JG will identify 340B-acquired drugs subject to the payment reduction; modifier TB will identify qualifying 340B drugs exempt from the reduction, including pass-through and qualifying non-opioid pain management drugs; and modifier ND will identify drugs acquired outside the 340B program. Table 2 outlines these modifier requirements.

Table 2. CY 2027 Drug Claim Modifiers

Hospital Type	Pass-Through Drug (SI "G")	Separately Payable Drug (SI "K)	Non-Opioid Treatment for Pain Relief Drug (SI "K1")	Packaged Drug (SI "N")
340B Drugs				
340B Hospitals, non-excepted and excepted Off-Campus PBDs	TB	JG	TB	TB
Children's Hospitals	TB	TB	TB	TB
PPS-Exempt Cancer Hospitals	TB	TB	TB	TB
Rural Sole Community Hospitals	TB	TB	TB	TB
Non-340B Drugs				
All OPPS Hospitals, non-excepted and excepted Off-Campus PBDs	ND	ND	ND	ND Option

The 7.5% budget neutrality increase and 2% remedy offset will affect payments for non-drug OPPS services, including hospital outpatient neurosurgical services, across all hospitals. The net impact will vary based on each hospital's 340B status, drug utilization, and outpatient service mix. Hospitals with significant 340B drug utilization will also face reduced reimbursement for separately payable drugs, potentially affecting the resources available to support neurosurgical care and maintain patient access to medically necessary services.

Site-of-Service Payment Adjustments: Off-Campus Imaging

In the proposed rule, CMS proposed expanding its existing methodology for controlling unnecessary increases in the volume of services furnished in excepted off-campus provider-based departments. The policy currently applies to certain clinic visits and drug administration services. CMS proposed extending the MPFS-equivalent payment methodology to imaging without contrast services furnished in these departments.

CMS finalized this policy for CY 2027, which applies to Healthcare Common Procedure Coding System (HCPCS) codes assigned to imaging without contrast APCs, including certain bone density scans, x-rays, ultrasounds, CT scans, and MRIs. Services furnished in qualifying excepted off-campus PBDs will be paid at the applicable MPFS-equivalent rate rather than the OPPS rate. Rural sole community hospitals are exempt from this policy. The Agency estimates that this change will reduce Medicare Part B expenditures by approximately $260 million in CY 2027, including approximately $190 million in Medicare savings and $70 million in reduced beneficiary premiums and cost-sharing obligations.

Neurosurgical evaluation and treatment planning depend on timely access to diagnostic imaging, including CT scans and MRIs, to identify and characterize brain and spinal conditions, assess disease progression, and determine the need for surgical intervention. Reductions in reimbursement for imaging furnished in qualifying excepted off-campus hospital departments may create financial disincentives to maintaining these services at those locations. If hospitals respond by reducing imaging capacity, relocating services, or consolidating outpatient departments, patients could face longer travel distances, delays in obtaining diagnostic studies, and additional barriers to timely neurosurgical evaluation and treatment. These changes may be particularly consequential for patients who require frequent imaging or coordinated access to imaging and neurosurgical services.

Inpatient Only List

In the CY 2026 OPPS final rule, CMS established a three-year phase-out of the IPO list, with the stated goal of eliminating the list entirely by CY 2029. The Agency removed nearly 300 procedures in CY 2026 and proposed removing an additional 637 services for CY 2027.

The AANS/CNS have expressed significant concerns with eliminating the IPO list as a whole. Although advances in surgical techniques, anesthesia, imaging, and perioperative care have made some historically inpatient procedures appropriate for outpatient treatment in selected patients, these advances do not establish that all remaining procedures can be safely or appropriately furnished in an outpatient setting.
The IPO list provides an important framework for identifying procedures that, because of their complexity, invasiveness, or postoperative care requirements, are generally appropriate for inpatient payment. Under 42 CFR § 419.23, CMS has historically evaluated individual procedures against specific clinical and payment criteria before removing them from the list.

In comments on the proposed rule, the AANS/CNS urged CMS to retain a clinically meaningful IPO list and conduct a rigorous, procedure-specific review before transitioning complex neurological procedures to outpatient payment. The AANS/CNS emphasized that decisions regarding the appropriate site of service must account for patient-specific clinical circumstances, postoperative risks, hospital capabilities, and the resources necessary to manage complications.

The AANS/CNS also raised concerns regarding the potential consequences of IPO elimination, including:

- **Patient Safety:** Complex neurosurgical procedures may require intensive postoperative monitoring, neurological assessment, imaging, and immediate access to reoperation or other interventions. These capabilities may not be available in all outpatient settings.

- **Rural and Underserved Access:** The shift toward outpatient payment could create challenges for beneficiaries in communities where outpatient surgical infrastructure is limited.

- **Site-of-Service Pressure:** Removal from the IPO list could create expectations among Medicare Advantage organizations and other payers that outpatient care should be the preferred setting, even when inpatient care is clinically appropriate.

- **Beneficiary Cost Sharing:** Although outpatient care may offer lower cost sharing for some services, multiple outpatient services furnished during a single surgical episode may result in cumulative beneficiary costs that differ from those associated with an inpatient admission.

- **Administrative Burden:** Eliminating the IPO list may increase utilization review, documentation, prior authorization, and audit requirements for hospitals and physicians seeking inpatient payment for procedures no longer designated as inpatient-only.

- **Payment Adequacy:** Existing APC assignments may not adequately reflect the clinical complexity and resource requirements of certain procedures. The availability of an outpatient APC should not, by itself, establish that a procedure is appropriate for outpatient payment.

In the final rule, CMS finalized the removal of 637 additional services from the IPO list, covering the auditory, digestive, endocrine, female genital, hemic and lymphatic, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary clinical families.

CMS did not include the neurological, cardiovascular, or transplant clinical families in the CY 2027 removals. These procedures remain deferred until CY 2028. Neurological procedures remaining on the IPO list encompass a broad range of complex services, including:

- Burr-hole procedures;
- Craniectomy and craniotomy;
- Cranial decompression;
- Intracranial tumor surgery;
- Skull-base surgery;
- Cerebrovascular and intracranial vascular procedures;
- Aneurysm surgery;
- Intracranial angioplasty, stenting, and thrombectomy;
- Cranioplasty;
- Cerebrospinal fluid shunt procedures;
- Implanted neuroelectrode procedures; and
- Complex spine and spinal cord procedures.

These procedures may involve critical neurological structures and substantial postoperative risks. Whether an individual procedure can be safely performed on an outpatient basis depends on the patient's condition, the complexity of the procedure, and the availability of appropriate postoperative resources. The AANS/CNS will continue advocating for a procedure-specific review of the neurological clinical family before the CY 2028

rulemaking process. Any transition to outpatient payment should be supported by clinical outcomes, appropriate patient selection criteria, adequate APC reimbursement, and consideration of the resources necessary to provide safe care.

ASC Covered Procedures List

In conjunction with its continued phase-out of the IPO list, CMS expanded the ASC CPL to allow additional procedures to be paid when furnished in an ASC. For CY 2027, CMS proposed adding 618 procedures to the ASC CPL, corresponding to procedures proposed for removal from the IPO list. The proposal prompted concerns regarding patient safety, the capabilities of ASCs, and the appropriateness of adding procedures to the ASC CPL in the same year they are removed from the IPO list.

In comments, stakeholders urged CMS to consider the clinical characteristics and resource requirements of individual procedures before expanding the list. Concerns included the ability of ASCs to manage complications, provide appropriate postoperative monitoring, and transfer patients when hospital-level care becomes necessary.

In the final rule, CMS finalized the addition of all 618 proposed procedures and added one additional procedure, CPT code 64629, for a total of 619 additions for CY 2027.

CMS declined requests to restore its previous exclusion criteria or delay the addition of procedures removed from the IPO list. The Agency maintained that existing state and local regulations, ASC Conditions for Coverage, accreditation requirements, and physician clinical judgment provide sufficient safeguards. CMS also reiterated that inclusion on the ASC CPL does not establish that a procedure must be performed in an ASC or that the ASC is necessarily the most appropriate setting for a particular beneficiary.

The continued expansion of the ASC CPL reinforces the importance of preserving physician discretion when determining the appropriate site of service. The availability of outpatient payment should not create an expectation that complex neurosurgical procedures must be performed in an ASC or other lower-cost setting. The AANS/CNS will continue to emphasize that decisions regarding the appropriate surgical setting must be based on patient-specific clinical needs, procedural complexity, and the capabilities of the facility—not payment policy alone.

Prior Authorization for Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators

Neurosurgical procedures, including cervical fusion with disc removal (CPT codes 22551 and 22552) and implanted spinal neurostimulators (CPT code 63650), have been subject to prior authorization in the Medicare fee-for-service program since July 1, 2021. The CY 2027 proposed rule did not include any changes to this prior authorization requirement.

In comments on the CY 2027 proposed rule, the AANS/CNS continued to oppose the use of prior authorization for these neurosurgical procedures. The AANS/CNS also detailed how use of prior authorization for these neurosurgical procedures is inconsistent with the federal government's longstanding efforts to address the opioid crisis by expanding access to evidence-based non-opioid approaches to pain management.

CMS stated in the final rule that because the proposed rule did not include any changes to the existing prior authorization requirements for cervical fusion with disc removal or implanted spinal neurostimulator services, these comments were outside the scope of CY 2027 rulemaking.

As such, prior authorization remains in effect for cervical fusion with disc removal and implanted spinal neurostimulator services under the Medicare fee-for-service program, despite AANS/CNS concerns about the lack of supporting evidence and the potential for delays in care. These requirements create administrative barriers for neurosurgeons and may delay access to medically necessary procedures for patients with cervical

spine disease and chronic pain. For patients who may benefit from spinal neurostimulation as a non-opioid approach to pain management, authorization delays or denials may further impede access to evidence-based treatment options. The continued use of prior authorization also places additional administrative burdens on neurosurgical practices and may disrupt timely treatment planning and continuity of care.

QUALITY REPORTING UPDATES AND POLICIES

Electronic Clinical Quality Measures Data Validation Framework

In the proposed rule, CMS proposed to expand the Hospital Outpatient Quality Reporting Program's existing data validation process to include eCQMs.

The AANS/CNS supported this change, highlighting the importance of increasing the use of more seamless and automatic methods of reporting and analyzing quality data. The AANS/CNS emphasized that accountability for data validation accuracy should remain at the hospital rather than individual clinician level. In response, CMS agreed that streamlining and aligning the Agency's requirements across programs reduces the administrative burden on clinicians while ensuring the accuracy and reliability of data.

Because reporting under the Hospital Outpatient Quality Reporting Program occurs at the facility rather than individual practitioner level, the finalized policy will not directly affect individual neurosurgeons' quality scoring. However, neurosurgeons and clinical staff may experience indirect operational effects if hospitals rely on their documentation or assistance to support eCQM reporting and validation. More broadly, the expansion reflects CMS's continued emphasis on transitioning to electronic and automated methods of quality measurement across quality programs.

Requests for Information (RFIs)

Advance Care Planning Electronic Clinical Quality Measure

The proposed rule included an RFI on incorporating an advance care planning measure into the OPPS Quality Reporting Program. The proposed measure would evaluate the percentage of adult patients whose electronic health record includes either an advance care planning document (such as an advance directive, health care proxy, or Physician Orders for Life-Sustaining Treatment [POLST]) or documentation of an advance care planning discussion that resulted in a documented care decision during the measurement period.

In comments to the proposed rule, the AANS/CNS urged caution and expressed that the measure should be narrowly tailored to appropriate patient populations. The AANS/CNS relayed key guiding principles that should inform any future advance care planning measure, including that the measure must be targeted to appropriate patient populations and clinical circumstances; include appropriate exclusions; meaningfully drive quality improvement; retain accountability at the hospital/facility level; not be extended to ASCs; and be adequately tested prior to implementation.

CMS acknowledged recommendations to limit such a measure "to patients, procedures, departments, or encounters where advance care planning is clinically relevant." CMS stated that the Agency appreciated the comments it received on this topic and stated that it would "continue to take all concerns, comments and suggestions into account for future development of measures related to advance care planning;" however, CMS did not respond to individual comments.

CMS did not finalize the adoption of an advance care planning measure in the OPPS Quality Reporting Program. Accordingly, hospital outpatient departments will not be required to report advance care planning data, including from neurosurgeons, for purposes of the Hospital Outpatient Quality Reporting Program.

Stratification of ASC All-Cause Transfer/Admission Measure

The proposed rule included an RFI on stratifying the ASC All-Cause Hospital Transfer/Admission measure by phase of care. Such stratification would distinguish whether a patient is transferred pre-procedure, intra-procedure, or post-procedure, with the goals of providing greater clinical context when evaluating transfer and admission rates and allowing for more meaningful comparisons of ASC quality and performance.

The AANS/CNS supported this stratification, describing how pre-procedure, intra-procedure, and post-procedure transfers or admissions represent clinically different events and may have very different implications for quality. The AANS/CNS urged CMS to also consider mechanisms to distinguish potentially preventable transfers from medically appropriate escalation of care, regardless of the point at which the transfer is initiated. The AANS/CNS cautioned the Agency that any modification to the all-cause transfer admission measure should not create a direct or indirect incentive to delay or avoid a medically necessary hospital transfer.

CMS did not finalize stratification of the ASC All-Cause Hospital Transfer/Admission measure by phase of care. Accordingly, ASCs will continue reporting the existing measure without distinguishing between pre-procedure, intra-procedure, and post-procedure transfers. However, potential future stratification could provide greater clinical context for evaluating ASC quality and performance.

ADDITIONAL RESOURCES

For more information on the CY 2027 Medicare Hospital Outpatient Prospective Payment System and the Medicare Ambulatory Surgical Center Payment System Final Rule, visit the Fact Sheet for CY 2027 OPPS/ASC Final Rule.

Visit the CMS press release, Medicare Outpatient Final Rule Expands Surgical Options, Lowers Out-of-Pocket Costs for 340B Drugs.

To view the final rule on the *Federal Register*, visit: https://www.federalregister.gov/d/2026-22739.