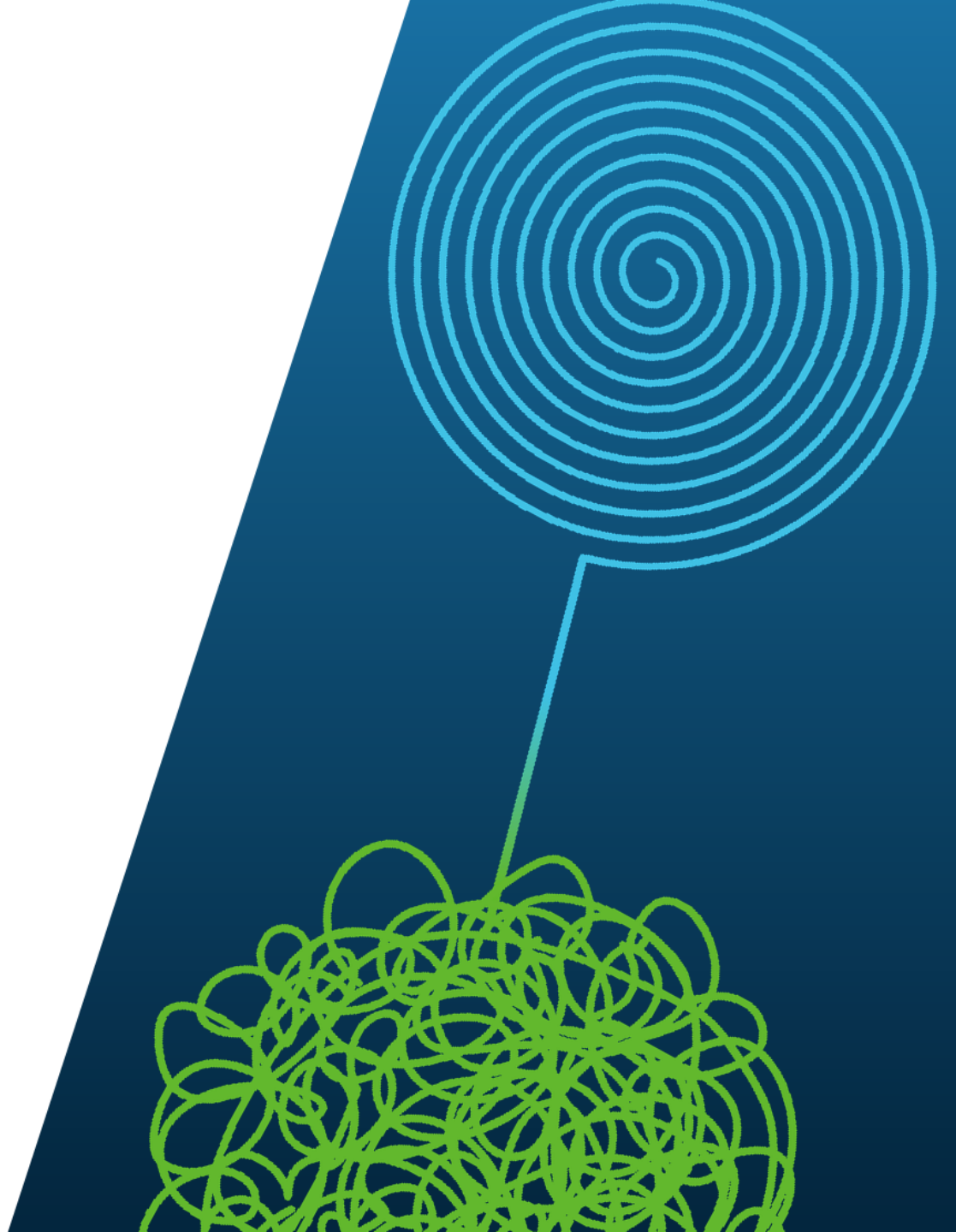
Healthcare Regulatory Roundup #115

CY 2027 Proposed Rules:

OPPS, Home Health, and ESRD Updates Providers Need to Know

July 22, 2026



Introductions

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Today's Agenda

1. CY 2027 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule
   - ✓ Expansion of the Site Neutral Policy
   - ✓ Payment Adjustments Under the 340B Drug Pricing Program
   - ✓ Changes to the Inpatient-Only List and ASC Covered Procedures List
   - ✓ Revisions to the Outpatient Quality Reporting Program
   - ✓ Implementing Unique Identifier and Attestation Requirements for All Off-Campus Provider-Based Departments
2. CY 2027 End-State Renal Disease PPS Proposed Rule
3. CY 2027 Home Health PPS Proposed Rule
   - ✓ Provider Enrollment Policy Changes to Reduce Improper Payments

CY 2027 Hospital Outpatient Prospective Payment System Proposed Rule

Comments due August 31

CY 2027 Payment Changes

- Proposed 2.4 percent increase to the conversion factor
  - Based on hospital inpatient market basket increase of 3.2 percent less productivity adjustment of 0.8 percent
  - Base rate $102.004 (currently $91.415)
  - Statutory 2.0 percentage point reduction in payments for hospitals that fail to meet HOQR requirements
- Combined impact of proposed policies results in overall 1.9 increase in OPPS payments
- Outlier threshold increased from $6,225 to $7,100
- 2027 ASC conversion factor = $57.766 (currently $56.322)
  - Continues to use hospital market basket update factor for ASC payment system
  - Statutory 2.0 percentage point reduction for ASCs not meeting quality reporting requirements

Inpatient Only List/ASC Covered Procedures List

- **2026:** Announced plans to phase out inpatient only list (IPO) over three years
  - Initial removal of 285 mostly musculoskeletal services for CY 2026
- **2027:** Proposing removal of 637 additional procedures
  - Auditory, digestive, endocrine, female genital, mediastinum and diaphragm, hemic and lymphatic, integumentary, male genital, maternity and delivery, respiratory, urinary
- More complex neurological, cardiovascular, and transplant services deferred to CY 2028
- Corresponding changes to ASC Covered Procedures List (CPL)
  - Added 618 new procedures, many of which were those removed from IPO list

OPPS 340B “Remedy”

- Increases the reduction to the OPPS conversion factor from 0.5 percent to 3 percent for non-drug items and services
  - Takes “pay-back” period to approximately end of CY 2029
  - Impact on base rate:
    - Base rate of $102.004 reduced to $99.015 (currently $91.415)
  - Not applicable to hospitals enrolled in Medicare after January 1, 2018 (will receive full payment update)

Payment for 340B Drugs

- Use of 340B Drug Cost Acquisition Survey
  - Approximately 43.6% of eligible hospitals responded to the survey
    - 29.8% submitted usable acquisition cost information
  - Survey results
    - Hospitals acquired non-340B drugs at approximately 2.7 to 2.8% above ASP
    - Hospitals acquired 340B drugs at approximately 33.4% below ASP
  - Proposes to pay most 340B-acquired drugs at ASP minus 33.4%
    - Non-340B drugs would continue to be paid at ASP plus 6%
  - CMS intends conduct survey every 4 years
- Exempts rural SCHs, children's hospitals, and PPS-exempt cancer hospitals

Payment for 340B Drugs (*continued*)

- Will require use of modifiers on all drug claims:
  - **-JG:** 340B-acquired drug subject to payment reduction
  - **-TB:** exempt 340B drug that continues to receive ASP + 6%
  - **"-XX":** placeholder to identify all separately payment non-340B drugs
- Resulting budget neutrality necessitates an increase in OPPS payments for non-drug services by an estimated 8.44% in non-drug payments

Payment for 340B Drugs (*continued*)

- Section 1833(t)(14)(D)(ii) and (iii) of the Social Security Act:
  - *"The Secretary … shall conduct periodic … surveys to determine the hospital acquisition cost for **each** specified covered outpatient drug for use in setting the payment rates … to generate a statistically significant estimate of the average hospital acquisition cost for **each** specified covered outpatient drug."*
- CMS OPPS Proposed Rule (page 41889):
  - *"We seek comment on our proposal to apply a single discount factor to the ASP for 340B-acquired drugs in lieu of calculating individual acquisition cost amounts for 340B-acquired drugs."*

Site Neutral Payments

- Imaging services without contrast in exempted (grandfathered) off-campus provider-based departments (PBDs)
  - Will be paid at 40% of OPPS rate to equate to physician fee schedule rate
  - Applies to:
    - **APCs 5521-5524:** imaging without contrast
    - **APC 8004:** ultrasound composite
    - **APC 8005:** CT/CTA without contrast composite
    - **APC 8007:** MRI/MRA without contrast composite
  - Does not apply to rural SCHs
  - Will not be budget neutral

Provider-Based Departments

- Requirements of the Consolidated Appropriations Act, 2026, Section 6225
  - Requirement that hospitals submit a provider-based status attestation for all off-campus outpatient "departments"
    - CMS will develop standardized attestation form to replace the current MAC-specific templates
      - **DRAFT AVAILABLE:** https://www.cms.gov/files/document/proposed-section-6225-attestation-format.pdf
    - All off-campus HOPDs providing services on or before January 1, 2028, would be required to submit an attestation between January 1, 2026, and December 31, 2027
    - New departments after January 1, 2028, must submit during the two years prior to when billed services are delivered
    - Recurring attestations not to exceed every 5 years
  - Requirement for all off-campus outpatient "departments" obtain a National Provider Identifier that is separate from the hospital's main NPI
    - Proposed rule also requires an update to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

Price Transparency

- RFI regarding hospital price transparency (Strengthening the Standardization and Comparability of Hospital Price Transparency Data)
  - Discussion of possible improvements to machine readable files, with focus on free text fields:
    - Contract terms
    - Clarity regarding outlier payments
    - Stop loss provisions
    - Rate tiers
    - Carve outs
  - Seeking comment on potential approaches to enhance the comparability and usefulness of the consumer-friendly display of shoppable services
  - Requesting feedback regarding modification to or elimination of the deemed compliance policy for Internet-based price estimator tools

Outpatient Quality Reporting Program

- Proposes removal of Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patient
  - Beginning with CY 2027 reporting period and CY 2029 payment determination year
- Retains Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure
- Proposes updates and refinements to validation and validation reconsideration procedures
- Requests comments on future adoption of an Advance Care Planning eCQM

Other Items of Note

- Software as a Medical Service (SaMS)
  - Approximately 36 HCPCS codes, most assigned to new technology APCs
  - Uses status indicator O1
- Expansion of HOPD prior authorization program to include botulism toxin injection procedures
  - Would be effective July 1, 2027

CY 2027 End-Stage Renal Disease PPS Proposed Rule

Comments Due August 23, 2026

Proposed Payment Changes

- Increase base rate to $299.55
  - $17.84 increase over current rate of $281.71
  - Update includes permanent addition to the base rate of $15.96 to account for inclusion of phosphate binders
  - Proposed change would increase total payments to ESRD facilities by 1.1% (2% increase for hospital-based facilities and 1.1% for freestanding facilities)
- Proposes to increase the labor-related share of the base rate from 55.2% to 63.5%

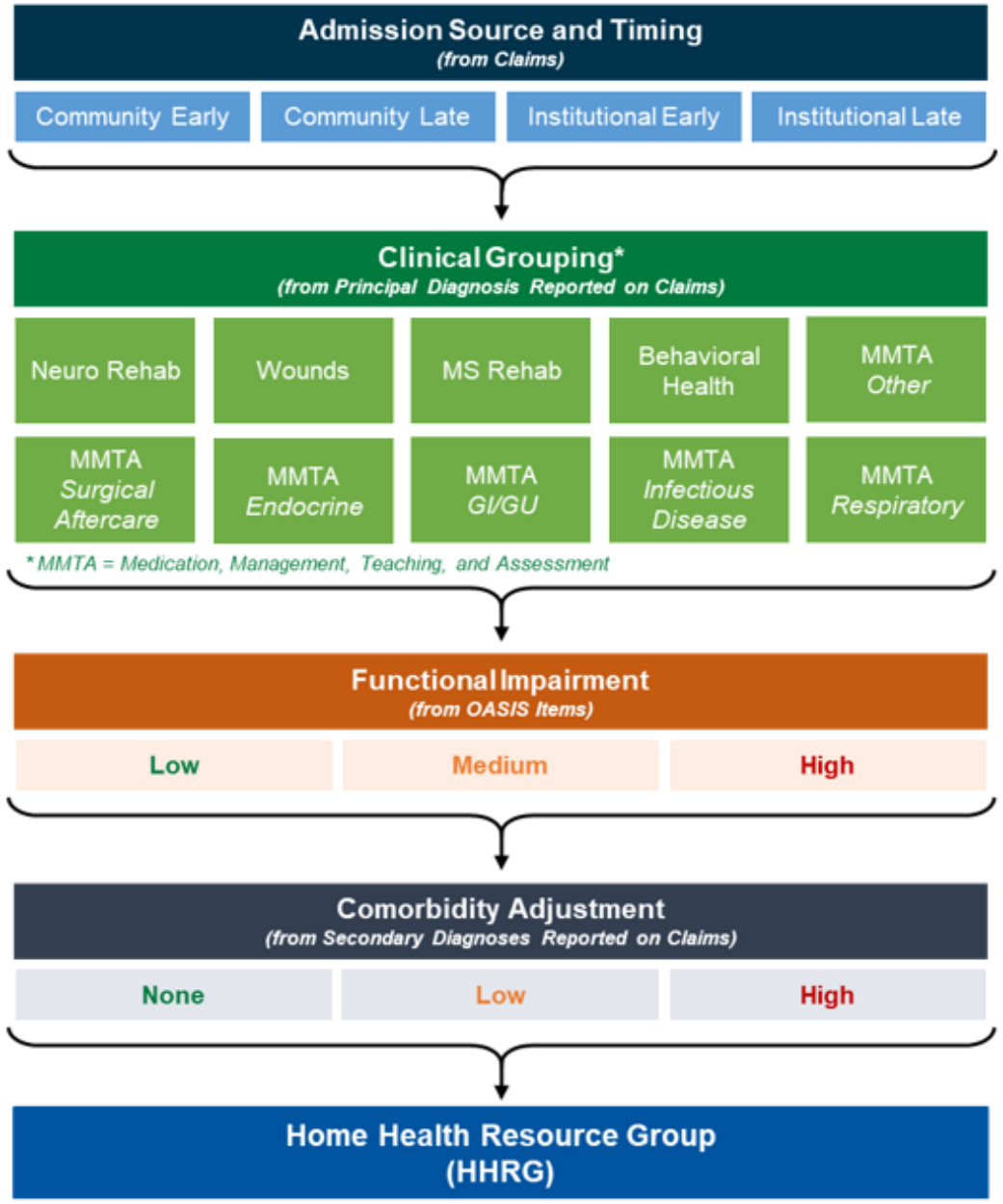
- Update outlier services fixed dollar loss (FDL) and Medicare allowable payment (MAP) amounts using more current data
  - Increases attributed to projected utilization of drugs currently paid as transitional drug add-on payments becoming ESRD outlier services in 2027
  - Pediatric beneficiaries:
    - FDL increase from $162.43 to $206.43
    - MAP increase from $50.19 to $60.86
  - Adult beneficiaries:
    - FDL increase from $14.80 to $114.98
    - MAP increase from $23.68 to $41.28

ESRD Quality Incentive Program (QIP)

- Changes for payment year 2029
  - Removal or modification of three measures
    - Hypercalcemia measure and replace with Facility-Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients measure (Hyperphosphatemia)
      - Intended to assess patient-focused clinical outcomes while stressing nutritional counseling, phosphorus-binding medications, and prescription adjustments
    - Medication Reconciliation reporting measure
    - COVID-19 Vaccination Coverage Among Healthcare Personnel
  - Proposes to update the NHSN Bloodstream Infection in Hemodialysis Patients clinical measure methodology
- Requests public comment on inclusion of Dialysis Facility Discussion of Patient Life Goals Patient-Reported Outcome Performance Measure in the ESRD QIP

CY 2027 Home Health PPS Proposed Rule

Comments due August 31



Patient-Driven Groupings Model (PDGM)

- National, standardized 30-day period payment rate (previously 60-day episode)
- Agency-specific adjustments
  - Wage Index
  - Quality Reporting Program
  - Value-Based Purchasing Model
- Case-specific adjustments
  - Each 30-day period assigned to one of 432 Home Health Resource Groups based on beneficiary's health conditions and care needs
  - Additional adjustments for low-utilization and partial periods, outliers, rural add-on payment

Base Rate and Weights

- 2.4% increase to current payments (**$240 million over CY 2026**)
  - 3.1% market basket increase, less 1.0% productivity adjustment and a 0.3% increase related to outlier payments tie to a lower fixed dollar loss (FDL) ratio (down from 0.37 to 0.29)
    - Change in FDL expected to increase outlier payments by approximately $50 million
- Budget neutrality reduction to the base rate of 3.0%
  - Accounts for differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures due to implementation of PDGM and 30-day unit of payment
- Requests input on creating a HH-specific wage index using alternate data source such as BLS

30-Day Period Payment Rates

TABLE 26: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 Proposed HH Payment Update Factor	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 Proposed National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.021	$2,156.98	0.9700	$2,092.27

The proposed CY 2027 national standardized 30-day period payment rate for an HHA that does not submit the required quality data would be updated by 0.1 percent (the proposed CY 2027 home health payment update percentage of 2.1 percent minus 2 percentage points) and is shown in table 27.

TABLE 27: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor Minus 2 Percentage Points	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.001	$2,114.73	0.970	$2,051.29

Home Health Measures and Programs

Quality Reporting Program

- No proposed changes to the HH QRP measures
- Data submission deadline proposed to move from 4.5 months after the reporting quarter to no late than the 15th day of the second month after the end of the calendar quarter

Value-Based Purchasing Model

- No proposed changes to the HH VBP program
- Proposed rule includes discussion on ways to align the QRP and HH VBP programs
  - Aligning reporting periods
  - Updating scoring methodologies

CAHPS

- No proposed changes to the HH CAHPS measures
- Proposes to revise the assessment and submission timeframes for HH CAHPS data to a calendar year basis
  - Now July through June

Provider Enrollment Policy Changes to Reduce Improper Payments

Applicability

- Although included in HH PPS proposed rule, policy changes would be applicable to ***all*** Medicare providers and suppliers
- Proposals include:
  - All revocations of Medicare enrollment would be retroactive to the date of noncompliance rather than 30 days after notification of removal
  - Adds new grounds for revocation or denial of enrollment; may deny/revoke if:
    - A provider has a suspended/revoked license in another state
    - Suspended from Medicaid or another federal healthcare program
    - Deemed to present a high risk of fraud, waste or abuse (high-risk geographic concentrations)
    - Convicted of a federal or state misdemeanor related to sexual assault or financial misconduct within the last 10 years
  - Expanded policy would include similar suspensions/revocations for entity owners/managing employees and organizations

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