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CMS Released CY 2027 HOPPS Final Rule

On November 4th, 2026, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 Hospital Outpatient Prospective Payment System (HOPPS) final rule. The finalized changes will be effective January 1, 2027.

For CY 2027, CMS finalized an OPPS conversion factor of $99.970, which incorporates a 2.3% OPD fee schedule increase and several additional adjustments. These include a 0.9952 wage index budget-neutrality adjustment, a 0.9996 adjustment for the 5% cap on individual hospital wage index reductions, a 0.9992 COLA budget-neutrality adjustment, a 0.9996 cancer hospital payment adjustment, and a 1.075 budget-neutrality adjustment for the 340B drug payment policy. CMS also applied a 0.07 percentage point adjustment for the difference in projected pass-through spending, resulting in the final CY 2027 conversion factor of $99.970.

CMS also finalized a reduced conversion factor of $98.011 in the calculation of payments for hospitals that fail to meet the Hospital OQR Program requirements (a difference of -1.959 in the conversion factor relative to hospitals that met the requirements).

CMS estimates that total payments to OPPS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) for CY 2027 will be approximately $114.4 billion, an increase of approximately $11 billion compared to estimated CY 2026 OPPS payments.

CY 2027 HOPPS Finalized Imaging APCs

APC	APC Title	CY 2026 Payment Rate	CY 2027 Finalized Payment Rate
5521	Level 1 Imaging without Contrast	$88.91	$96.23
5522	Level 2 Imaging without Contrast	$106.81	$116.37
5523	Level 3 Imaging without Contrast	$243.77	$266.71
5524	Level 4 Imaging without Contrast	$558.25	$614.24
5571	Level 1 Imaging with Contrast	$179.20	$196.70
5572	Level 2 Imaging with Contrast	$356.43	$393.93
5573	Level 3 Imaging with Contrast	$800.90	$901.43

Comprehensive-APC Policies

CMS conducted an annual review and finalized no changes in this rule to the current number of 74 C-APCs. Table 4 lists all final C-APCs for CY 2027, all of which were established in past rules.

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Changes to the Inpatient Only List (IPO)
For CY 2026 and subsequent years, CMS proposed to eliminate the IPO list through a 3-year transition, completing the elimination by January 1, 2029. In this final rule, CMS is continuing to phase out the IPO list by removing 637 services from the auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory and urinary clinical families from the IPO list for CY 2027.

Finalized CPT Code Placements
In this final rule, CMS placed CPT code 71271 for low dose CT lung cancer screening in its existing APC of 5522 with payment rate of $116.37. The finalized placement for code G0296 (visit to determine lung LDCT eligibility) is APC 5822, with a payment rate of $118.75.

CMS placed CPT code 76145 for medical physics dose evaluation for radiation exposure that exceeds institutional review threshold (including reports) in its existing APC of 5723 with payment rate $429.64 for CY 2027.

CMS placed code C8001 (3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy) into APC 1503 with payment rate of $150.50 for CY 2027.

CMS placed codes 0559T (Anatomic model 3D printed from image data set(s): first individually prepared and processed component of an anatomic structure) and 0561T (Anatomic guide 3D printed from image data set(s): first anatomic guide) into APC 5734 with Q1 status indicator and payment rate of $149.81 for CY 2027.

CMS placed code 77402 for level 1 radiation oncology treatment delivery into APC 5621 with payment rate of $130.01 for CY 2027. CMS placed codes 77407 and 77412 for levels 2 and 3 radiation oncology treatment delivery into APC 5623 with payment rate of $535.88 for CY 2027.

OPPS Payment for Software as a Medical Service (SaMS)
As coding for SaMS continues to rapidly increase and technologies evolve, establishing a consistent and timely payment methodology for these services is a priority for CMS. In this final rule, CMS is finalizing a change in Medicare terminology for software-based technologies from Software as a Service (SaaS) to Software as a Medical Service (SaMS) to more appropriately refer to these technologies. As CMS is considering these rapidly evolving SaMS, CMS is finalizing the proposal to assign them to New Technology APCs as

an interim step toward a broader payment policy. Table 83 in the final rule lists the services requested to be designated as SaMS and their final CY2027 APC assignments.

Software as a Medical Service (SaMS) CY 2027 Final APC Placements & Payment Rates

CPT Code	Long Descriptor	CY 2026 APC	CY 2026 Payment Rate	Final CY 2027 APC	Final CY 2027 SI	Final CY 2027 Payment Rate
75577	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computer tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	1511	$950.50	1511	O1	$950.50
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	$950.50	1511	O1	$950.50
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	$950.50	1511	O1	$950.50

CPT Code	Long Descriptor	CY 2026 APC	CY 2026 Payment Rate	Final CY 2027 APC	Final CY 2027 SI	Final CY 2027 Payment Rate
0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	1511	$950.50	1511	O1	$950.50
0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs	1511	$950.50	1511	O1	$950.50
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1508	$650.50	1508	O1	$650.50
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset	1508	$650.50	1508	O1	$650.50

CPT Code	Long Descriptor	CY 2026 APC	CY 2026 Payment Rate	Final CY 2027 APC	Final CY 2027 SI	Final CY 2027 Payment Rate
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	$950.50	1511	O1	$950.50
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure)	1511	$950.50	1511	O1	$950.50
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	5523	$243.77	1504	O1	$250.50
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic	5523	$243.77	1504	O1	$250.50

CPT Code	Long Descriptor	CY 2026 APC	CY 2026 Payment Rate	Final CY 2027 APC	Final CY 2027 SI	Final CY 2027 Payment Rate
	resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain					
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	5523	$243.77	5523	Q1	$266.71
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	5724	$877.34	1510	O1	$850.50

Separate Payment for Diagnostic Radiopharmaceuticals

In the CY 2025 HOPPS final rule, CMS finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than $630 for 2025.

For CY 2027, CMS finalized the proposal to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $630 threshold forward. Based on this methodology, CMS trended the $630 threshold forward and rounded the resulting dollar amount ($634.80) to the nearest $5 increment, which yields a final diagnostic radiopharmaceutical packaging threshold figure of $635 per day for CY 2027.

CMS finalized the proposal to pay for qualifying diagnostic radiopharmaceuticals based on the arithmetic Mean Unit Cost (MUC) in CY 2027 while continuing to encourage manufacturers to submit Average Sales Price (ASP) data for possible future payment use.

Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services

In the CY 2026 OPPS/ASC proposed and final rules, CMS indicated they had concerns about the services within the imaging without contrast APCs (APCs 5521-5524). CMS stated that imaging without contrast services are often high-volume, low-intensity services that can be provided in OPDs or freestanding offices. In the CY 2026 OPPS/ASC proposed rule, CMS stated they had concerns these services had experienced unnecessary growth and that a volume control method may be appropriate to apply in the future. CMS solicited comments on this issue in the CY2026 HOPPS proposed rule.

For CY 2027, CMS is finalizing a policy to apply this volume control method to imaging without contrast services, which include certain bone density scans, x-rays, ultrasounds, CT scans and MRIs, furnished in excepted off-campus PBDs. Specifically, CMS is using the agency's authority under section 1833(t)(2)(F) of the Social Security Act to apply the Physician Fee Schedule equivalent payment rate for any HCPCS codes assigned to the imaging without contrast ambulatory payment classifications (APCs) when provided at an off-campus PBD excepted from section 603 of the Bipartisan Budget Act of 2015. As with the existing volume control method for off-campus clinic visits and drug administration services, CMS is exempting rural Sole Community Hospitals from this policy.

For CY 2027, CMS estimates this provision would reduce Medicare Part B expenditures by approximately $260 million in the first year, including approximately $190 million in Part B savings and approximately $70 million in reduced beneficiary premiums. In addition, beneficiary cost-sharing obligations are estimated to decrease by approximately $70 million in the first year.

Reduced Payments for 340B-Acquired Drugs Based on the Medicare OPPS Drugs Acquisition Cost Survey

Beginning with CY 2027, CMS will pay for 340B-acquired drugs at ASP minus 28%, based on a 2026 hospital drug acquisition cost survey showing that 340B hospitals often acquire drugs at substantially lower costs. CMS estimates the policy will reduce Original Medicare drug payments by $4.35 billion and beneficiary cost sharing by $1.1 billion in the first year, with affected beneficiaries saving an average of about $900. Because the change must be budget neutral, the $4.35 billion reduction will be redistributed through higher OPPS payments for non-drug services.

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CY 2027 Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the Prior 340B Payment Policy

Beginning in CY 2027, CMS will increase the existing reduction to the OPPS conversion factor for non-drug items and services from 0.5% to 2% to recover $7.8 billion in additional payments hospitals received from CY 2018 through CY 2022 under the prior 340B payment policy. The 2% reduction will apply to most hospitals, excluding those that enrolled in Medicare after Jan. 1, 2018, and is expected to remain in place through CY 2031, when CMS estimates the full $7.8 billion will have been recovered.

Hospital Quality Reporting Programs

This final rule includes relatively few substantive changes to CMS quality reporting programs but continues several important trends relevant to radiology. Most notably, CMS finalized the proposed updates to the validation and appeal procedures for digital quality measures (dQMs) in the Hospital Outpatient Quality Reporting (OQR) Program, reflecting the agency's continued move toward electronically generated, validated quality data.

Hospital Outpatient Quality Reporting (OQR) Program

CMS is finalizing updates to the validation of Hospital Outpatient Quality Reporting Program data, including the validation of electronic clinical quality measure (eCQM) measures. CMS finalized the proposal to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination. While none of these finalized policies are specific to radiology, the continued emphasis on digital quality measurement, electronic reporting, and data validation may have future implications for radiology quality reporting, registry participation, and measure development activities.

While ACR acknowledges that the most significant issue for radiology is not a specific new measure requirement, but rather CMS's ongoing transition toward digital quality measurement and validation, which continues to shape the future direction of federal quality reporting programs.

Rural Emergency Hospital Quality Reporting (REHQR) Program

CMS did not make any updates to the REHQR Program, so this final rule does not affect radiology facilities, departments, or imaging services operating within Rural Emergency Hospitals. However, ACR will continue to monitor future rulemaking for possible changes related to quality measurement, reporting requirements, and digital quality initiatives.

The ACR is reviewing the final rule and will release a detailed summary in the coming weeks. If you have any questions, please email Kimberly Greck at kgreck@acr.org.

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