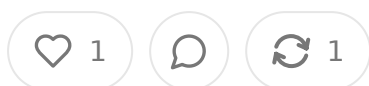


The Site-of-Care Migration Engine: The Company to Build on the CY2027 OPP and ASC Rule's IPO Phase-Out, Site-Neutral Imaging, 340B ASP-Minus-33.4-Percent Haircut, and Price Transparency RFI

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The Site-of-Care Migration Engine: The Company to Build on the CY2027 OPPS and ASC Rule's IPO Phase-Out, Site-Neutral Imaging, 340B ASP-Minus-33.4-Percent Haircut, and Price Transparency RFI

CMS just proposed a rule that reads like a forced eviction notice for surgery and imaging from hospital outpatient departments. Here is what is actually happening and why it matters for anyone building in healthcare...

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Abstract

Scope: CMS-1850-P, the CY2027 OPPS and ASC proposed rule, published July 2 2026, comment window open through August 31, 2026.

Core thesis: the rule is a multi-year federal subsidy for moving procedures and imaging out of the hospital outpatient department and into ASCs and physician offices, while gutting the 340B drug margin that used to fund hospital outpatient overhead.

The build: not another surgery center. A two-sided intelligence and steerage layer knows, per market and per code, what can now legally and safely move, what each actually gets paid, and how much the move saves and to whom.

Key figures that drive it: 638 codes coming off the inpatient-only list in year two three-year phase-out, 618 codes added to the ASC covered procedures list, site-r imaging without contrast saving roughly \$260 million in year one, 340B repricing ASP minus 22.1 percent worth about \$10.1 billion in 2026, the 340B remedy offsets jumping from 0.5 percent to 2 percent, roughly 3,500 HOPDs versus roughly 6,400 ASCs.

The cheat code: the Hospital Price Transparency RFI, which telegraphs that CMS is about to force the machine-readable files to get standardized and comparable, including the ugly contract mechanics (outlier payments, stop-loss, rate tiering, etc.). Clean fuel makes the engine cheaper and more defensible for whoever starts now.

Monetization: shared savings on redirected episodes, per-episode routing and coordination fees, then a take rate on independent-ASC enablement.

Biggest risks: it is still a proposed rule, commercial payers do not have to follow Medicare, MRF data may stay messy, and a large payer or ASC roll-up could try to build it in-house.

The short version for people who skim



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