Medicare Gives Clinical AI a Billing Identity Before It Has a Price Theory: The CY 2027 OPPS SaMS Proposal, th New O1 Status Indicator, the New Technology Bridge, and the Lab-Analysis Migration

JUL 22, 2026 • PAID

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Medicare just gave clinical AI a billing identity. It has not given it a price theory. That gap is the whole story in the 2027 OPPS proposed rule…

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Abstract

- The CY 2027 OPPS proposed rule, CMS-1850-P, does not create a universal payment category for clinical AI and does not price algorithmic value from f principles. Comments are due August 31, 2026.
- What it does: proposes an outpatient taxonomy for certain algorithmic clini services, a new status indicator (O1) that makes many of them separately pay and a temporary New Technology APC band to hold rates roughly steady wh CMS keeps arguing with itself about cost, evidence, packaging, and overuse.
- The vocabulary tell: CMS renames Software as a Service (a cloud business m to Software as a Medical Service, or SaMS. Cute, and telling.
- Not all of it gets paid separately. Across source-defined groups totaling 36 HCPCS codes designated as SaMS in Table 61, a subset would carry O1 whil others retain their existing status indicators (such as Q1, E1, N, or M) and packaging rules. Do not read this as “all the AI codes now get paid.”
- The rates are stability, not valuation. AI-QCT stays at 950.50 dollars even th a handful of early claims implied placement in the lowest New Technology A payment band. Optellum keeps its assignment even though claims implied a percent cut. This is legibility, not a value model.
- The sleeper is the lab move: CMS proposes to treat repeated algorithmic ana of stored test data as an “other diagnostic test,” pulling it off the Clinical Laboratory Fee Schedule.
- This did not start in 2026. HeartFlow got separate OPPS payment back in 2(MedPAC has been warning about bundle erosion and overuse the whole tim

Table of Contents

CMS gives clinical AI a billing identity before it has a price theory

The temptation with this proposal is to write the headline "Medicare starts payi AI," collect the clicks, and move on. Resist it, because it is wrong in both directi once. Medicare has paid for algorithmic clinical software since 2018, so this is n debut. And the CY 2027 OPPS rule does not actually price the value of AI, so th not a valuation either. What it is, and this is the useful framing, is CMS handing of algorithmic clinical services a billing identity before it has figured out what a them are worth. Legibility first, valuation later, maybe never.

That gap between "we can now see it in the claims" and "we know what to pay fo is the entire story, and it is a genuinely hard problem rather than bureaucratic dithering. The stuff CMS is trying to pay for does not behave like the stuff OPPS built to pay for. There is no gurney, no vial, no observable material resource to c out. There is a subscription, a per-click license, and a proprietary model whose a cost the vendor has every incentive not to disclose. So CMS is doing the only thi can do at this stage, which is create a place to put these services on a claim, flag

of them as separately payable, and buy itself time with a temporary rate band wh keeps asking the questions it has been asking, unresolved, for years. Everything is a variation on that theme.

← Previous