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The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1850-P — Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule for Calendar Year 2027

Dear Administrator Oz:

On behalf of AMGA, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (CMS-1850-P), published in the Federal Register on July 7, 2026.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

This year's proposed rule includes several significant payment and policy changes that will affect our members, including an accelerated timeline for recouping 340B remedy payments, a substantial reduction in payment for 340B-acquired drugs, continued expansion of site-neutral payment policy, new administrative requirements for off-campus hospital outpatient departments (HOPDs), and several program integrity and quality reporting proposals. AMGA is pleased to offer the following comments on key policy proposals included in the proposed rule.

AMGA's key recommendations:

- Withdraw the proposed 3% annual 340B remedy offset and retain a more gradual recoupment schedule.

- Reconsider or phase in the proposed payment reduction for 340B-acquired drugs and provide additional information regarding the representativeness and methodology of the acquisition cost survey.
- Assess the cumulative impact of site-neutral payment expansions on access to outpatient services before finalizing additional reductions.
- Establish clear review timelines, streamlined documentation standards, and meaningful procedural protections for the new off-campus HOPD attestation requirements.
- Implement appropriate patient-access and program-integrity safeguards before expanding prior authorization for botulinum toxin injection services.
- Minimize provider burden across the rule's administrative, quality-reporting, and domestic procurement initiatives.

Detailed comments on each policy proposal follow.

CY 2027 OPPS and ASC Payment Rate Update

CMS proposes to increase CY 2027 payment rates under both OPPS and the ASC payment system by 2.4%, reflecting a 3.2% hospital market basket increase reduced by a 0.8 percentage point productivity adjustment. CMS also proposes to extend use of the hospital market basket as the ASC payment system update factor for an additional year, through CY 2027.

AMGA appreciates CMS' continued reliance on the hospital market basket for ASC updates, which helps ensure ASC payment keeps pace with the actual cost of furnishing care. However, we remain concerned that the net 1.9% payment increase CMS projects for OPPS providers, after accounting for the proposed 340B remedy offset, understates the cumulative financial pressure facing health systems, particularly when considered alongside the other reductions discussed below. AMGA urges CMS to evaluate the adequacy of the payment update in the context of the rule's combined financial effects rather than considering each proposal in isolation.

340B Remedy

CMS proposes to increase the annual reduction to the OPPS conversion factor used to recoup 340B remedy payments from 0.5% to 3% for hospitals enrolled in Medicare before January 1, 2018. This change would accelerate full recovery of the $7.8 billion tied to the 2018–2022 underpayment period from CY 2041 to CY 2029.

AMGA opposes this proposal. CMS proposed a 2% acceleration in the CY 2026 OPPS/ASC proposed rule, but declined to finalize it after considering stakeholder feedback, indicating it would revisit the repayment methodology in CY 2027 rulemaking. AMGA is disappointed that CMS has returned with a proposal that is more aggressive, not less, than the one it declined to finalize last year. A 3% annual reduction would impose significant, immediate financial harm on health systems, particularly those serving low-income, rural, and underserved populations.

Financial Harm to Safety Net Providers

Under the original 340B remedy policy,[1] CMS estimated full repayment by CY 2041, allowing health systems time to absorb incremental reductions while maintaining stability. Compressing

[1] 88 FR 77150

the repayment period to CY 2029 dramatically increases the near-term financial shock to health systems. Many safety net facilities already operate on thin margins, and steep, front-loaded cuts of this magnitude threaten their ability to maintain essential services, sustain workforce pipelines, and invest in community health programs. AMGA urges CMS to withdraw this proposal and instead maintain a more gradual recoupment schedule.

Ramifications for Medicare Advantage Payment Structures

AMGA remains concerned that the proposed reduction to the OPPS conversion factor could produce unintended and inequitable downstream effects on the Medicare Advantage (MA) market. MedPAC has observed that Medicare FFS payment rates serve as an important reference point in negotiations between MA plans and providers and that MA payment rates for inpatient and outpatient services tend to be benchmarked to prevailing Medicare FFS payment amounts.[2] As a result, changes to the OPPS conversion factor may flow automatically into MA contracted payment rates, even when those changes are intended solely to recoup a discrete, historical FFS payment remedy.

In the CY 2026 OPPS/ASC final rule, CMS acknowledged that many MA contracts reference Medicare FFS rates but explained that it generally cannot dictate the terms of private contracts between MA organizations and providers. AMGA recognizes those statutory limitations. However, CMS should still assess and mitigate the foreseeable distortions created when MA plans routinely incorporate FFS policies into MA reimbursement methodologies. We believe CMS has the authority to proactively identify potential distortions predictably caused by its own policies and to provide guardrails focused on mitigating such unintended consequences.

The proposed reduction is a temporary recoupment mechanism tied to a specific historical FFS remedy, not an ordinary recalibration of hospital outpatient payment rates. Implementing it through the generally applicable OPPS conversion factor may therefore extend the recoupment beyond the providers and payments associated with the remedy. Because many MA payment arrangements reference FFS rates, the offset could reduce contracted reimbursement even where the underlying arrangement did not include a corresponding retrospective 340B adjustment. This structural mismatch could affect health systems, physician groups, health plans, and integrated payer-provider systems, particularly those serving substantial numbers of low-income and medically complex patients.

AMGA urges CMS to evaluate these broader market effects separately from its FFS budget-neutrality analysis and clarify that the offset is a temporary, FFS-specific reconciliation that does not reflect a change in the underlying cost or value of outpatient services. CMS should also consider a more targeted methodology, such as a separately identifiable adjustment or provider-specific reconciliation, that minimizes spillover into unrelated payment arrangements.

If CMS retains the conversion-factor approach, AMGA urges the agency to phase in the reduction; monitor its effects on provider reimbursement, contracting, network stability, and beneficiary access; and modify the policy if it produces material consequences unrelated to the remedy payments received.

[2] Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, ch. 4, pp. 139–143 (June 2026).

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

CMS proposes to reduce OPPS payment for 340B-acquired drugs from Average Sales Price (ASP) plus 6% to ASP minus 33.4%, effective January 1, 2027, based on the hospital acquisition cost survey CMS conducted following the CY 2026 OPPS/ASC final rule. CMS reports that only approximately 41% of eligible hospitals submitted usable survey responses. CMS proposes to exempt children's hospitals, PPS-exempt cancer hospitals, and rural sole community hospitals and to implement new billing modifiers (JG, TB, and a new "XX" modifier) to distinguish 340B, exempt, and non-340B drugs.

AMGA has significant concerns about this proposal. First, the fact that only 23.1% of 340B hospitals and 34.9% of all hospitals responded with data to the survey raises questions about whether the survey data are representative of the broader 340B hospital population.[3] Creating a new national payment methodology from one year's worth of data from fewer than a quarter of the nation's 340B hospitals would appear unnecessarily rushed, risking the implementation of an ill-informed payment policy that has a disproportionately large impact on providers serving the most vulnerable beneficiaries. Analyzing data from additional years (rather than from a single point in time) and incorporating data from more than 23.1% of the country's 340B hospitals would help inform policy with more robust information.

Before relying on the results to establish a permanent national payment policy, CMS should be transparent in sharing detailed de-identified and aggregated data received from survey respondents. Furthermore, prior to finalization of such a payment change, CMS should openly and clearly explain further how it adjusted for potential non-response bias particularly among 340B hospitals, differences in a greater number of and more meaningful hospital characteristics (e.g., geographic variation, academic center status, whether the hospital serves a designated medically underserved area, whether the hospital is a designated Disproportionate Share Hospital), and variation in drug purchasing arrangements. By employing a transparent and open process in partnership with health systems, CMS would gain the experience and information needed to derive an informed and sustainable 304B rate.

Second, an ASP minus33.4% rate represents a dramatic departure from current policy and, layered on top of the accelerated remedy repayment discussed above, would compound financial pressure on 340B hospitals in the same payment year.

AMGA urges CMS to reconsider both the timing and magnitude of this proposed reduction. At a minimum, CMS should phase in any reduction over multiple years, publish additional information regarding the survey methodology and respondent characteristics, and establish a process for periodically updating the payment rate based on more complete and representative acquisition data.

Expansion of Site-Neutral Payment Policy to Imaging Services Without Contrast

CMS proposes to expand its existing site-neutral payment policy by applying the site-specific Physician Fee Schedule (PFS)-equivalent rate to imaging-without-contrast services (APCs 5521–

[3] 91 FR 41880

5524, and APCs 8004, 8005, and 8007) furnished in off-campus provider-based departments (PBDs), with an exemption for rural sole community hospitals. CMS estimates this proposal would generate $260 million in total savings, including $70 million in reduced beneficiary cost-sharing.

We ask CMS to consider this proposal within the broader financial environment facing providers across the healthcare delivery system.

MedPAC's analysis indicates that hospital Medicare margins remain deeply negative, an estimated -12.1% in 2024, improving only modestly to a projected -10% in 2026. On the physician side, MedPAC has found that cumulative growth in the Medicare Economic Index has far outpaced cumulative fee schedule updates: 56% versus 14% from 2000 to 2024.[4] These trends span practice settings, whether health systems or independent group practices, and reflect a broader longstanding pattern in which Medicare reimbursement has not kept pace with the cost of delivering care.

Within that context, a number of AMGA members—integrated, multispecialty systems that maintain imaging capacity in off-campus PBDs to serve patients efficiently—have raised concerns about the cumulative effect of successive site-neutral expansions involving clinic visits, drug administration, and now imaging without contrast. These reductions may affect the financial viability of maintaining outpatient sites that provide integrated access to diagnostic, specialty, and follow-up services.

AMGA urges CMS to assess the cumulative impact of these layered reductions on access to imaging services, particularly in communities where off-campus PBDs may be the most convenient or only nearby option for patients. CMS should also consider targeted protections for facilities serving medically underserved areas or populations, rather than relying solely on a rural sole community hospital exemption.

Continued Phase-Out of the Inpatient Only List

CMS proposes to remove an additional 637 services from the Inpatient Only (IPO) list for CY 2027, continuing the three-year phase-out finalized in the CY 2026 rule and moving toward full elimination by January 1, 2029. The services proposed for removal span several clinical families, including auditory, digestive, endocrine, and respiratory procedures, among others.

AMGA encourages CMS to continue basing removal decisions on clinical appropriateness and stakeholder input, as it has done in selecting the clinical families proposed for this second phase. CMS should also ensure that providers and Medicare Administrative Contractors (MACs) receive adequate lead time and detailed guidance to update clinical, utilization-review, billing, and claims-processing systems before procedures lose inpatient-only status.

CMS should further clarify that removal from the IPO list does not establish a presumption that the outpatient setting is appropriate for every patient. Physicians must retain the ability to determine the appropriate site of service based on individual clinical circumstances,

[4] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, ch. 3 and ch. 4 (March 2026).

comorbidities, procedural complexity, and anticipated recovery needs.

Expansion of the ASC Covered Procedures List

CMS proposes to add approximately 618 additional surgical procedures to the ASC Covered Procedures List (CPL) for CY 2027, including procedures associated with the continued phase-out of the IPO list.

AMGA supports this expansion, which gives physicians and patients greater flexibility to choose the most clinically appropriate and cost-effective site of care. We encourage CMS to continue to apply rigorous clinical criteria in evaluating newly eligible procedures to ensure patient safety remains paramount as the CPL grows. CMS should also monitor outcomes associated with newly added procedures and preserve physician discretion to determine whether a hospital outpatient or inpatient setting is more appropriate for a particular patient.

Off-Campus Hospital Outpatient Department NPI and Provider-Based Attestation Requirements

Section 6225 of the Consolidated Appropriations Act, 2026, establishes new Medicare payment conditions for off-campus HOPDs beginning January 1, 2028. Affected departments must obtain and bill under a unique, location-specific National Provider Identifier (NPI), and hospitals must submit attestations demonstrating compliance with the provider-based requirements at 42 C.F.R. § 413.65. In this proposed rule, CMS proposes to codify the separate NPI requirement in a new § 419.23 and to make related changes to the attestation and provider-based regulations at § 413.65.

AMGA appreciates CMS' efforts to implement this statutory mandate in a structured manner, and we offer the following comments on specific elements of the proposal.

Proposed Definitions. CMS proposes to define an "off-campus outpatient department of a provider" to include remote hospital locations not located on the main provider's campus and to clarify that outpatient departments within 250 yards of a hospital's remote location would not be treated as being on the main provider's campus.

AMGA asks CMS to provide additional examples and sub-regulatory guidance clarifying how these definitions apply to complex or non-contiguous campus configurations, shared facilities, and co-located outpatient departments, to reduce the risk of inconsistent interpretation across MACs.

Standardized Attestation Form and Centralized Electronic System. CMS proposes to replace the current MAC-specific attestation templates with a standardized form submitted through a centralized electronic system and has published a draft form for comment.

AMGA supports standardizing the attestation process, which should reduce confusion and inconsistency across MAC jurisdictions. We urge CMS to provide stakeholders a meaningful opportunity to test and comment on the electronic submission system before it becomes mandatory; publish detailed technical specifications and user guidance well in advance of the applicable submission deadline; and establish a contingency process for system outages or technical failures that could otherwise jeopardize a health system's ability to submit a timely attestation.

Agency Review and Validation Process. CMS proposes a review and validation process that could involve CMS or MAC review, automated validation, and targeted documentation review, culminating in an approval notice. CMS would establish additional protocols through sub-regulatory guidance.

AMGA is concerned that the proposal does not include a defined timeframe within which CMS or its contractors must complete review and issue a determination. Given that payment for off-campus HOPD services will depend on a completed attestation, open-ended review timelines create a risk of payment disruption through no fault of the provider.

AMGA urges CMS to establish a specific review and determination timeframe, such as 60 or 90 days. CMS should also create a clear and expedited reconsideration or appeals pathway for hospitals whose attestations are denied or delayed.

Hospitals that submit complete and timely attestations should be protected from payment disruption while CMS or a MAC conducts its review. CMS should confirm that payment will continue during any timely initiated reconsideration or appeal.

Provider Documentation Requirements. CMS proposes to require health systems to maintain documentation demonstrating compliance and to produce it upon request, generally within 60 days. For providers attesting for multiple HOPDs, CMS is considering streamlined documentation requirements and has requested comment.

AMGA supports streamlined requirements for health systems attesting on behalf of numerous HOPDs. CMS should adopt a system-level or sampling-based approach rather than requiring duplicative, facility-by-facility documentation when underlying compliance elements (such as licensure, corporate structure, or financial integration) are common across sites.

We also ask CMS to confirm that the 60-day production period may be extended for good cause, particularly for systems responding to requests involving a large number of affected departments.

Attestation Timeframes. CMS proposes that HOPDs furnishing services on or before January 1, 2028, submit initial attestations between January 1, 2026, and December 31, 2027, and that HOPDs furnishing services thereafter attest within the two years prior to furnishing services.

AMGA is concerned that this proposed timeline compresses the effective preparation period available to health systems because part of the initial attestation window will have elapsed before publication of the final rule. We urge CMS to provide the maximum operational lead time permitted under the statute, clarify how health systems should proceed before the centralized system and final form are available, and protect health systems that submit complete attestations by the applicable deadline but have not yet received a determination.

CMS should also establish the subsequent (post-CY2028) attestation cadence in this rulemaking cycle, rather than deferring it to future rulemaking or guidance, to give health systems adequate lead time to plan for ongoing compliance obligations.

Prior Authorization for Additional Botulinum Toxin Injection Codes

CMS proposes to add eight additional botulinum toxin injection codes to the existing OPD prior

authorization program, effective for services furnished on or after July 1, 2027, citing utilization growth that CMS states it cannot otherwise explain.

AMGA is concerned that expanding prior authorization to additional codes will increase administrative burden on physician practices and may delay medically necessary treatment for patients relying on botulinum toxin injections for established clinical indications, including chronic migraine, spasticity, and other neurological or urological conditions.

AMGA asks CMS to publish the underlying utilization analysis supporting this proposal, including the extent to which growth is concentrated among particular codes, indications, provider types, or geographic areas. CMS should consider whether more targeted program-integrity interventions could address identified concerns without subjecting all services to prior authorization.

If CMS finalizes the proposal, it should establish clear clinical criteria, expedited review for time-sensitive treatment, continuity-of-care protections for patients receiving established maintenance therapy, and transparent denial and appeals data. CMS should also monitor treatment delays, interruptions in care, and disproportionate effects on patients with chronic or disabling conditions.

EMTALA — Accrediting Organization Deeming Authority

CMS proposes to require CMS-approved accrediting organizations (AOs) to incorporate certain EMTALA administrative compliance review elements into their existing accreditation processes. AOs would not be authorized to enforce EMTALA's clinical requirements involving medical screening, stabilization, transfer obligations, or receiving hospital responsibilities, which would remain subject to state survey agency and Office of Inspector General authority.

AMGA supports CMS' goal of reducing duplicative state investigations and unnecessary disruption to hospital operations. We ask CMS to ensure consistency in how different AOs implement these new administrative review elements, so that hospitals accredited by different organizations face comparable expectations. CMS should provide standardized survey guidance and establish a process for resolving conflicting AO and state survey agency findings.

Hospital OQR and ASCQR Program Proposals

CMS proposes to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from both the Hospital OQR and ASCQR Programs, in favor of continued reliance on the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure, which CMS believes is more directly tied to patient outcomes.

AMGA supports this proposal because it reduces reporting burden while preserving a more clinically meaningful outcome measure.

CMS also proposes updates to the Hospital OQR validation and validation appeals processes, including incorporating eCQM data into validation, reducing the validation selection pool from 500 to 400 hospitals beginning with the CY 2030 payment determination, and eliminating the requirement that hospitals resubmit previously submitted materials as part of a reconsideration request.

AMGA supports these burden-reduction proposals, particularly the streamlined reconsideration process. We ask CMS to ensure that the criteria used to select hospitals for eCQM validation are transparent, consistently applied, and clearly communicated in advance.

Finally, CMS requests information on the potential addition of an Advance Care Planning eCQM to the Hospital OQR Program and on stratifying the All-Cause Transfer/Admission measure in the ASCQR Program by phase of care.

AMGA appreciates the opportunity to weigh in on these concepts as they are developed and would welcome the opportunity to provide detailed member feedback when CMS presents specific measure specifications. CMS should not adopt either concept until the measures have undergone appropriate testing for validity, reliability, attribution, and unintended consequences.

Request for Information on Potential Voluntary IPPS Payment for Domestic PPE and Essential Medicine Procurement

AMGA supports CMS' consideration of a voluntary payment adjustment to encourage health systems to purchase domestically manufactured PPE and essential medicines. AMGA supports the goal of strengthening domestic-supply chain resilience, but any future policy should provide a meaningful financial incentive without shifting substantial verification and reporting burdens to health systems.

AMGA urges CMS to place responsibility for certifying domestic manufacturing status on manufacturers, rather than requiring health systems to independently audit supply-chain claims. CMS should maintain a centralized and regularly updated list of eligible products and establish a clear definition of domestic production, particularly for medicines whose active ingredients, finished dosage forms, and packaging may originate in different countries.

CMS should also establish a transparent methodology for calculating and updating the cost differential between domestic and non-domestic products. AMGA recommends avoiding a claims-based approach if a cost-report-based approach could achieve the same goal with less administrative burden.

Any additional payment should be sufficient to offset the higher cost of domestic procurement and should not be financed through reductions to other hospital payments. CMS should also avoid arbitrary aggregate payment caps that could weaken incentives for health systems to enter into longer-term domestic purchasing arrangements.

Finally, any future policy should account for circumstances in which qualifying products are unavailable, available only in limited quantities, or priced above CMS's standardized payment assumptions.

Conclusion

AMGA appreciates the opportunity to comment on this year's OPPS/ASC proposed rule and urges CMS to carefully consider the cumulative financial and administrative impact of these proposals—particularly the accelerated 340B remedy repayment, the proposed 340B drug payment reduction, and the new HOPD attestation requirements—on health systems that serve Medicare beneficiaries.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

Jerry Penso, MD, MBA
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