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September 11, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010

**RE: OPPS & ASC Proposed Rule (CMS-1834-P)**

Dear Administrator Oz:

On behalf of the American Independent Medical Practice Association ("AIMPA"), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") Calendar Year 2026 OPPS and ASC Proposed Rule (CMS-1834-P) ("Proposed Rule").[1] CMS has shown bold leadership in the Proposed Rule that will help realize the Trump Administration's goals of restoring competition in the healthcare market for the benefit of all Americans. Our comments focus on those aspects of the Proposed Rule that will effectuate these goals for Medicare beneficiaries and the physicians and other providers who care for them.

We believe we offer a unique perspective on key issues arising under the Proposed Rule. AIMPA is the country's first national, multi-specialty advocacy organization devoted exclusively to the interests of physicians caring for patients in independent medical practices. AIMPA represents more than 600 independent medical practices in 45 States. These practices include over 12,000 physicians who provide high-quality, affordable health care for approximately 25 million patients each year.

Our comments to the Proposed Rule focus on four issues impacting Medicare beneficiaries' access to high-quality, affordable care at independent medical practices:

- We support CMS's proposal for expansion of site-neutral payment to drug administration services at all off-campus, hospital outpatient departments ("HOPDs") as a method of controlling unnecessary increases in the volume of outpatient services provided at HOPDs;

[1] 90 Fed. Reg. 33476 (July 17, 2025).

- We support the expansion of site-neutral payments for clinic visits at on-campus HOPDs and respond to CMS's request for additional information;

- We support CMS's expansion of the ambulatory surgery center covered procedures list ("ASC CPL") and the proposed changes to general standards and exclusion criteria—a critical step to restore competition in the healthcare market—as well as the corresponding removal of procedures from the Inpatient-only list; and

- We encourage CMS to complete the survey of hospitals' acquisition costs for outpatient drugs—consistent with the U.S. Supreme Court's decision in *American Hospital Association et al. v. Becerra*[2]—that will provide the Agency with the empirical data needed to reduce payments for 340B drugs to more accurate levels that will save the Medicare program and Medicare beneficiaries billions of dollars.

As CMS continues to implement critically important site-neutral payment structures and support policies that will help shift care into the independent practice setting, we urge CMS to obtain from Congress additional statutory authority to shift savings achieved under prospective payment systems, such as the OPPS, to fund an inflation adjustment to the Physician Fee Schedule ("PFS").

## I. CMS should finalize its proposal to expand site-neutral payment to drug administration services furnished by excepted off-campus provider-based departments and identify additional services that should be subject to site-neutral payment.

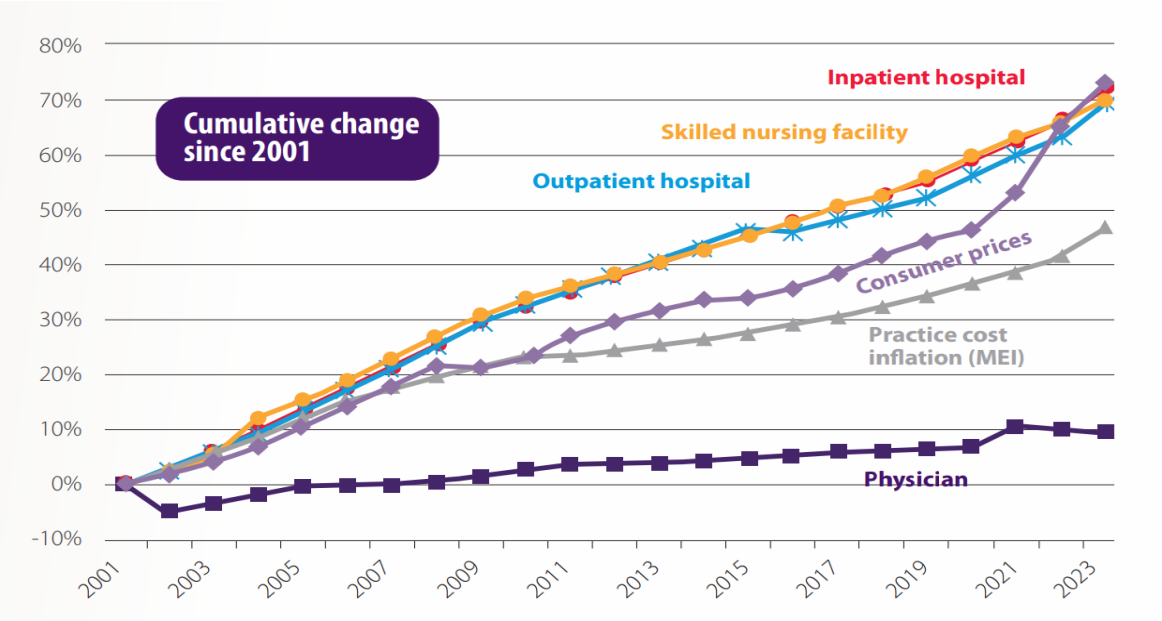
We appreciate CMS recognizing that "[m]any healthcare services can be performed in multiple settings" and though "there is little variation in the service provided across settings, the Medicare Trust Fund and Medicare beneficiaries typically pay more when that service is performed in an OPD than when the same service is performed in a physician office."[3] CMS is also correct that this unjustified payment differential has created a perverse incentive to shift care to an HOPD from a physician office or ASC, even when those services can be provided safely in these alternative, lower-cost settings.[4]

It is no surprise, then, that hospitals now dominate the healthcare marketplace. In 2022 and 2023, they acquired 2,800 additional physician practices. Hospitals owned nearly 70,000 physician practices as of January 2024. That number has grown 12% since 2019, when CMS began implementing site-neutral payment policies at new off-campus OPDs.

In 2012, hospitals and large health systems employed just one-fourth of physicians. Today, they employ more than half of all physicians. In the last five years, nearly 75,000 doctors have become employees of hospitals and health systems.

[2] 142 S. Ct. 1896 (2022).
[3] 90 Fed. Reg. at 33685.
[4] See *id*.

Unfortunately, without bold action from CMS and the Trump Administration, this problem will get worse. As the graph below shows, Medicare reimbursement for inpatient hospitals, hospital outpatient centers, and skilled nursing facilities has increased by around 70% over the past two-plus decades, while physician reimbursement has increased at a fraction of that rate—less than 10%. At the same time, the cost of operating a physician practice has increased by nearly 50%. All told, Medicare payments to physicians have *declined* more than 30% after accounting for inflation.




*Credit: American Medical Association*

Given these financial headwinds, it is no wonder that many independent physicians have been forced to close their practices or accede to buyout offers from hospitals or large health systems. Medicare reimbursement to physicians simply has not kept up with the cost of staffing, rent, insurance, and other operational expenses.

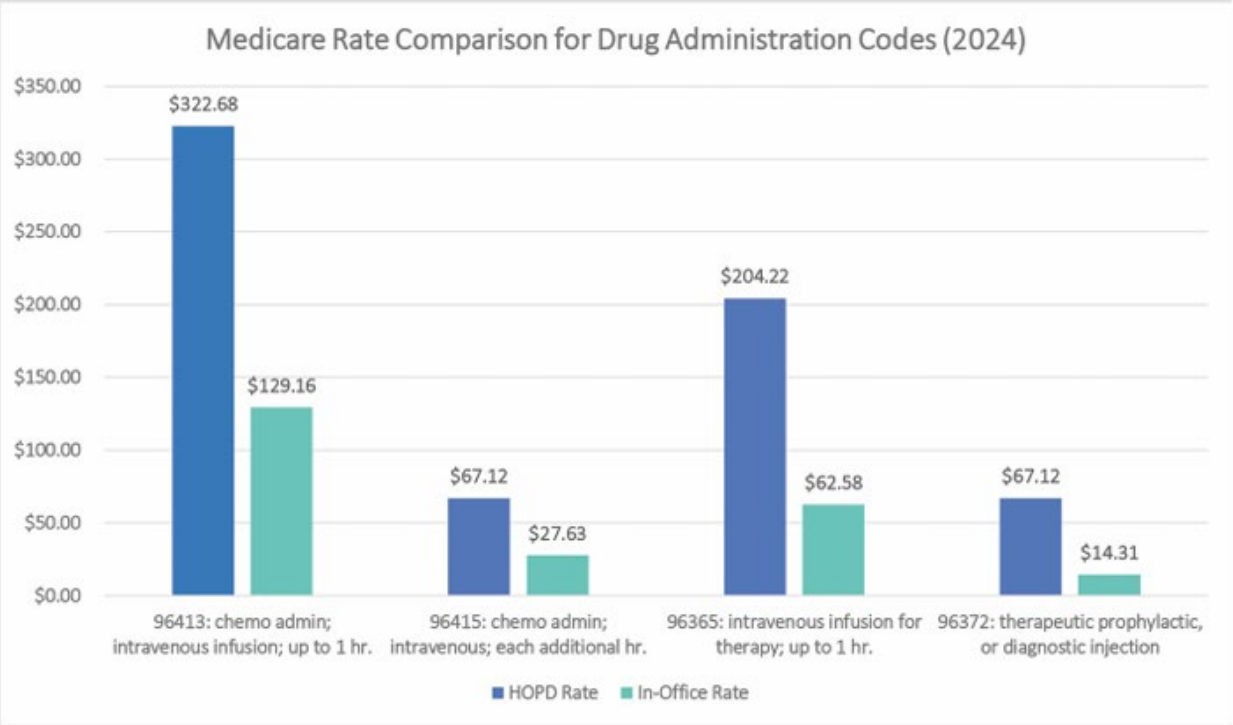
During President Trump's first term, CMS took an important step to fight consolidation by reducing payment for clinic visits furnished in excepted off-campus, HOPDs. Despite that action, hospitals and health systems are still purchasing independent practices at an alarming rate, given the lack of a sustainable payment structure under the PFS.

As CMS recognizes, there are serious ramifications for the Medicare program and for tens of millions of Medicare beneficiaries when hospitals buy physician practices. According to a 2024 study of five specialties (cardiology, gastroenterology, medical oncology, orthopedics, and urology) by healthcare consulting firm Avalere, total Medicare expenditures per beneficiary per year increased by an average of more than $1,300 in the 12 months after a physician moved from an unaffiliated private practice to a hospital affiliation.

A July 2025 peer-reviewed study focusing on the impact of practice affiliation on the cost of care showed that HOPDs received up to 861% of the reimbursement from Medicare that independent

physician practices in their medical offices and ASCs received for the same services.[5] This disparity was even greater when looking at payments from commercial insurers, with HOPDs receiving as much as 1,346% of the reimbursement that independent practices and ASCs received.[6] The study also found that Medicare beneficiaries treated by hospital-affiliated physicians had just a 37% chance of receiving care in the lowest-cost setting (either medical office or ASC), further compounding the cost-of-care problem created by the difference in reimbursement.[7]

These market realities are why it is so important for CMS to take steps such as the Agency's proposal to establish the PFS-equivalent payment rate for any HCPCS codes assigned to the drug administration ambulatory payment classifications ("APCs") when provided at an excepted off-campus HOPD. The following graph demonstrates that, in 2024, the administration fee for intravenously delivered drugs reimbursed by Medicare was significantly lower for drugs delivered in the independent practice setting than in an HOPD:




*Credit: Infusion Providers Alliance*

[5] Deepak Kapoor, et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, Journal of Market Access and Health Policy (2025), *available at* https://www.mdpi.com/2001-6689/13/3/36 (examining the cost of care for physicians practicing in the specialties of cardiology, gastroenterology, orthopedics, and urology).
[6] *Id.*
[7] *Id.*

In CY 2025, because of the cut in physician pay under the PFS and the increase in OPPS rates, the disparity for CPT Code 96413 between the HOPD and physician office setting was even more dramatic. As CMS noted:

> "HCPCS code 96413—which describes chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug—is one of the most frequently billed drug administration codes in the OPPS. In 2025 this service has a physician office payment rate of around $119 and an OPPS payment rate of approximately $341, making the same chemotherapy infusion service 186% more expensive in the OPD than in the physician office."[8]

Between 2024 and 2025, the payment rate for CPT code 96413 went down by $10 in the physician office setting and up by approximately $19 in the hospital outpatient setting—***even though it is the identical service in both settings***. This perverse financial incentive encourages hospitals to try to capture more drug administration volume by acquiring physician practices that can send patients to hospitals' on-campus or excepted off-campus OPDs. **Although CMS has only proposed the change for *off-campus* HOPDs, we would also support changing the code for any HOPD, whether *on-campus or off-campus*.**

We appreciate CMS taking this first step toward implementing site-neutral changes, but we hope CMS views this as just the beginning of bold action to eliminate hospitals' incentive to acquire independent medical practices. As CMS noted when it quoted the U.S. Court of Appeals for the D.C. Circuit, "'[i]t is reasonable to think that Congress . . . would have wanted the agency to avoid causing unnecessary volume growth with its own reimbursement practices.' *Am. Hosp. Ass'n,* 964 F.3d at 1245."[9]

**Accordingly, we urge CMS to finalize its proposal to set payment for drug administration services at excepted off-campus HOPDs at the PFS-equivalent rate. AIMPA stands ready to work with CMS to identify additional services across medical specialties for which site-neutral payment policies should apply to save the Medicare program and beneficiaries billions of dollars.**

## II. AIMPA supports CMS's proposal to pay for clinic visits conducted at on-campus HOPDs at the PFS-equivalent rate.

In CY 2019, CMS removed the payment incentive for clinic visits in *off-campus* OPDs by making the payment rate the same as the PFS-equivalent payment rate for all off-campus OPDs.[10] That action by CMS during President Trump's first term was an important step in furtherance of site-neutral payment policy. But, as CMS recognizes in the Proposed Rule, there is more work to be done. The clinic visit is still the most utilized service across the OPPS and over 60% of clinic visits are furnished at *on-campus* sites.[11] We believe it is prudent to establish site-neutral payment for

[8] 90 Fed. Reg. at 33686.
[9] *Id*. at 33685.
[10] *See id*. at 33691.
[11] *Id*.

on-campus clinic visits, as it is likely that the vast majority of patients are receiving the exact service they would receive at an off-campus HOPD clinic or independent medical practice.

In fact, independent medical practices routinely lease space from medical office buildings, which in some cases are located on the same campus as a hospital. These independent practices provide the same clinic visit service, which could be within 250 yards of the main buildings of a hospital, but at a lower cost.

In the Proposed Rule, CMS requested information regarding the extent to which clinic visits performed at HOPDs are "necessary" or "unnecessary"—given that clinic visits can safely be performed in other, lower-cost settings—and whether it is appropriate to include on-campus clinic visits when considering how to address unnecessary volume increases at HOPDs. We believe a vast majority of clinic visits at on-campus HOPDs can be performed safely at other sites of service and do not need to be provided at an on-campus HOPD. Most routine clinic visits (and though outside the scope of this Proposed Rule, routine testing and imaging) can be delivered just as safely, effectively, and efficiently in lower-cost non-HOPD settings.

Take cardiology. Most office-based cardiology evaluation and management ("E/M") services are performed within an ambulatory office setting, outside the four walls of a hospital. Absent the extension of site-neutral payments at these sites, the Medicare program and its beneficiaries bear extra costs simply because physicians provide the services in the hospital setting. This results in increased costs for the Medicare program and its beneficiaries, with no documented benefit to patients. In fact, many cardiology services have been moved to the ASC Covered Procedure List ("CPL") as described below; it makes little sense not to equalize payment for E/M services between the HOPD and independent practice settings.

We recognize that there could be limited instances in which there is a need for clinic visits to be furnished at an on-campus HOPD to access diagnostics or multi-disciplinary services that are only available at a hospital. But such decisions should be made by clinical teams. Any increase in payment as a result of the decision to furnish care in an on-campus clinic should be documented in the medical record. We encourage CMS to consider application of a modifier and corresponding guidance to justify higher OPPS rates under these limited circumstances.

Site-neutral payment for on-campus clinic visits would level the competitive landscape across healthcare delivery settings, reduce unnecessary healthcare spending, and encourage more efficient, cost-effective care delivery. Implementing site neutrality would improve healthcare cost control by removing incentives for hospital-driven consolidation, boosting access to care, and making care more affordable for patients.

We appreciate CMS recognizing that there is a need to expand site-neutral payment policy across a broader array of services and requesting information about other services for which the Agency should develop a method to control unnecessary increases in the volume of covered HOPD services by paying a PFS-equivalent rate for services provided at excepted off-campus HOPDs. We agree with CMS that imaging services without contrast are an appropriate set of services to which site-neutral payment can be applied to curb unnecessary increases in the volume of HOPD

services (APCs 5521-5524).[12] In particular, all electrocardiograms, exercise stress testing, and non-invasive cardiovascular imaging services (echocardiography, vascular ultrasound, SPECT imaging, PET imaging, PET/CT imaging, CT imaging, MR imaging) should be subject to site-neutral payment, given the lack of evidence to support added costs for off-campus HOPDs that necessitate a higher payment rate than what is paid in the independent practice setting.

But this only scratches the surface of procedures and other health care services appropriate for application of site-neutral payment. Take gastroenterology as an example. There is no justification for the Medicare program and beneficiaries paying two or three times as much when a colonoscopy or endoscopic procedure is performed in a hospital HOPD as compared to an independent ASC. CMS should apply site-neutral payment to the following procedures: CPT code 43235 (diagnostic esophagogastroduodenoscopy ("EGD")), CPT code 43239 (EGD with biopsy), CPT code 45378 (diagnostic colonoscopy), CPT code 45380 (colonoscopy with biopsy, single or multiple), CPT code 45385 (colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique with polypectomy).[13]

More broadly, there can be no doubt that removing payment incentives from site-of-service determinations would provide beneficiaries with greater access to care at sites other than the higher-cost on-campus and off-campus HOPD setting. A recently published peer-reviewed study found generally that site-of-care cost differentials contribute materially to healthcare expenditures, and strategies such as site-neutral payments are needed to mitigate the impact of historical and future physician practice migration.[14] Specifically, the study found that across 32 high-volume procedures reviewed, the HOPD was the highest-cost site of care, when compared to the ASC or physician office, and that total Medicare reimbursement for care delivered in the HOPD was 1.2 to 8.6 times greater than for care delivered in the highest-volume, lower-cost setting (ASC or physician office).[15]

Although the study examined how physician practice affiliation can impact site-of-care cost differentials, the findings suggest that the cost impact of migration in physician affiliation may be mitigated by payment strategies that reduce such differentials. Such migration of physicians from independent practice to hospital employment reduces beneficiaries' access to care, including clinic visits, at sites other than on-campus. Site-neutral payments would reduce the incentive for hospitals to acquire independent practices and thereby improve access and choice for patients.

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[12] *Id*. at 33690.

[13] The practical implications for patients of the unsupportable dual payment system for identical procedures furnished in the HOPD versus ASC setting cannot be overstated. The average payment by a Medicare beneficiary for a colonoscopy with removal of polyp (CPT code 45385) is more than $100 higher in an HOPD ($283) as compared to in an ASC ($174). See https://www.medicare.gov/procedure-price-lookup/cost/45385/. For CPT code 43235 ($210 in HOPD vs. $123 in ASC), https://www.medicare.gov/procedure-price-lookup/cost/43235; CPT code 43239 ($213 in HOPD vs. $126 in ASC), https://www.medicare.gov/procedure-price-lookup/cost/43239; CPT code 45378 ($217 in HOPD vs. $132 in ASC), https://www.medicare.gov/procedure-price-lookup/cost/45378; CPT code 45380 ($273 in HOPD vs. $164 in ASC), https://www.medicare.gov/procedure-price-lookup/cost/45380.

[14] Kapoor, et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, Journal of Market Access and Health Policy (2025), *available at* https://www.mdpi.com/2001-6689/13/3/36.

[15] *Id.*

**Therefore, we support CMS's proposal for site-neutral payment of on-campus clinic visits and urge the Agency to use this as a foundational step for expanding site-neutral payment policy in future years.**

### III. AIMPA supports CMS's proposal to add 276 codes to the ASC Covered Procedure List and, correspondingly, to remove 271 codes from the Inpatient-only List.

AIMPA commends CMS for continuing to modernize the ASC CPL in a manner that reflects contemporary clinical evidence, enhances beneficiary choice, and advances CMS's goal of advancing high-value, patient-centered care. CMS is appropriately proposing to add 276 procedures to the ASC CPL for CY 2026 by removing certain general standard and general exclusion criteria and moving them to a new section as nonbinding physician considerations for patient safety. By expanding the CPL—and removing 271 codes from the Inpatient-only ("IPO") list—CMS is acknowledging the maturation of surgical techniques that allows for these surgeries and other procedures to be done in a lower-cost site of service without compromising quality.

By broadening the CPL and proposing to eliminate the IPO list over the next several years, CMS will generate material savings for Medicare beneficiaries and the Medicare program. These proposals, if finalized, will improve beneficiary access to timely surgical care and prioritize clinical judgment as the proper determinant for where patients can receive their care. As research has confirmed, outcomes between services payable in the HOPD setting that do not appear on the ASC CPL are remarkably similar, even adjusting for risk.

**For these reasons, we urge CMS to add the full slate of proposed procedures to the ASC CPL, empowering physicians to exercise professional judgement regarding site-of-service and expanding beneficiary choice while safeguarding quality.**

### IV. CMS can save the Medicare program and its beneficiaries billions of dollars by completing the survey of hospitals' acquisition costs for outpatient drugs and reestablishing payments under the 340B program at ASP minus 22.5% or at an even lower level.

CMS has known since the Supreme Court's 2022 decision in *AHA v. Becerra* that a cost acquisition survey is necessary to reduce the unjustifiably inflated payments made for 340B drugs. Unfortunately, the prior Administration failed to conduct the cost acquisition survey in the two-and-a-half years following the decision in *AHA v. Becerra*, so we are incredibly appreciative that CMS is prioritizing the survey at the start of President Trump's second term. This will enable CMS to set accurate payment rates in the CY 2027 OPPS/ASC proposed rule to reduce the payments for 340B drugs from the current ASP + 6% to the prior level of ASP minus 22.5%, or at an even lower level as justified by the results of the survey. Swift action is needed to fix market distortions and eliminate wasteful spending that results in more care shifting from the lower cost physician office setting to the more costly hospital setting.

We share CMS's concern about the broken 340B program, which fuels vertical consolidation by hospitals and drives up costs for Medicare and its beneficiaries. 340B hospitals are incentivized to acquire independent medical practices to increase the number of patients that ultimately are eligible for 340B discounted drugs.

A well-documented example of abuse was reported by the *New York Times* in an investigative piece that found that Bon Secours Mercy Health in Virginia used profits from the 340B program at its community hospital to open new clinics at suburban covered entities that, on paper, are subsidiaries of Richmond Community Health.[16] Meanwhile, the hospital began slashing departments, services, and staff at the community hospital. Notably, Bon Secours closed the intensive care unit at the community hospital, which had been serving an already under-resourced neighborhood.

This is not an isolated example. A 2021 study in the *American Journal of Managed Care* found that hospitals that entered the 340B program did not increase their provision of uncompensated care more than hospitals that are not in the program.[17] Essentially, "nonprofit" hospitals are using the 340B program to pad their bottom lines by charging insurers and patients huge markups for the discounted drugs—and then using those resources to buy up competitors and consolidate local markets.[18]

CMS knows that keeping reimbursement at ASP + 6% for 340B hospitals is not a "proper" rate and, in fact, results in gross overpayment to those hospitals. CMS has previously cited government studies that found that lowering reimbursement for 340B hospitals from ASP + 6% to ASP minus 22.5% likely did not go far enough in establishing an appropriate reimbursement level for 340B-acquired drugs.[19] A March 2016 Report from HHS-OIG estimated that discounts across all 340B providers average 33.6% of ASP.[20] Additionally, CMS has previously acknowledged that some reports have found 340B hospitals benefitting from discounts as high as 50%.[21] These data are consistent with MedPAC's finding that "payments hospitals receive for 340B drugs (even at ASP minus 22.5%) are higher than the drug's discounted acquisition cost under the 340B program (and these discounts are growing)."[22]

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[16] Thomas, Katie and Silver-Greenberg, Jessica, "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits," *New York Times*, Sept. 24, 2022.

[17] Desai, Sunita and McWilliams, J., "340B Drug Pricing Program and Hospital Provision of Uncompensated Care," *American Journal of Managed Care*, Oct. 11, 2021.

[18] Okon, Ted, "Hospitals and for-profit PBMs are diverting billions in 340B savings from patients in need," STAT (July 7, 2022), *available at* https://www.statnews.com/2022/07/07/for-profit-pbms-diverting-billions-340b-savings/ (last accessed Aug. 28, 2025).

[19] OPPS Final Rule for CY 2019, 83 Fed. Reg. 58818, 59018 (Nov. 21, 2018).

[20] OIG March 2016 Report; Government Accountability Office, "Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals," GAO-15-442 (June 2015) (estimating the amount of the 340B discount at 20% to 50%); HHS Office of Inspector General, "Part B Payments for 340B-Purchased Drugs," November 2015, *available at* https://oig.hhs.gov/oei/reports/oei-12-14-00030.pdf (last accessed Aug. 28, 2025).

[21] 83 Fed. Reg. at 59020.

[22] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," (March 2020), *available at* https://medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf (last accessed Aug. 28, 2025).

To continue paying 340B hospitals at ASP + 6% without engaging in a cost acquisition survey would contradict clear Congressional intent that the 340B program "maximize scarce Federal resources as much as possible, reaching more eligible patients, and providing care that is more comprehensive."[23] Moreover, continuing to pay 340B hospitals at ASP + 6% will drive even more services, including drug treatment for patients with cancer, into the more expensive hospital outpatient setting. And as CMS knows, this market dynamic will encourage hospital-physician practice consolidation because hospitals will be able to continue expanding their profit margins on drugs provided by the acquired practices.[24] This vicious cycle must be stopped.

**CMS should complete the necessary survey of acquisition costs as soon as possible and use those findings to establish an accurate payment level for 340B hospitals on a prospective basis, rather than continuing to pay 340B hospitals at the unsupportable level of ASP + 6%. We have no doubt that payment of ASP minus 22.5%, or quite possibly at an even lower level, will be validated as more than adequate to cover 340B drug acquisition costs**.

A properly-calculated payment level for 340B drugs will save the Medicare program billions of dollars. We urge CMS and the Trump Administration to support Congressional action that would use these savings—and other savings generated from an expansion of site-neutral payment policy—as a foundation for applying a Medicare Economic Index ("MEI") inflation adjustment to PFS payment rates. Such combined action would help restore competition to the healthcare market and benefit tens of millions of Medicare beneficiaries.

## V. Request for Action.

We thank CMS for the opportunity to comment on the Proposed Rule. We urge CMS to take the following actions as it finalizes updates to Medicare payment policies and rates for the OPPS and ASC settings.

- Finalize the proposal to expand site-neutral payment to drug administration services furnished by excepted off-campus HOPDs.

- Finalize the proposal for site-neutral payment of on-campus clinic visits and work with AIMPA and others in the physician community over the next year to identify additional opportunities for expanded site-neutral payment across a broader array of services to control unnecessary increases in the volume of services in the HOPD setting.

- Finalize the proposal to update the ASC CPL through the addition of 276 potential surgery or surgery-like codes and the corresponding removal of 271 codes from the IPO list.

[23] H.R. Rep. No. 102-384(II), at 12 (1992).
[24] Desai and McWilliams, "Consequences of the 340B Drug Pricing Program," New England Journal of Medicine, Feb. 8, 2018, *available at* https://www.nejm.org/doi/full/10.1056/nejmsa1706475 (last accessed Aug. 19, 2025).

- Complete the survey of the acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS and use those findings to establish an accurate payment level for 340B hospitals on a prospective basis.

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AIMPA thanks CMS for spearheading efforts to fix our healthcare delivery system and ensure access to high-quality, affordable care for millions of Americans. AIMPA stands ready to serve as a continued resource to the Administration as we tackle these issues together. Please do not hesitate to reach out to AIMPA President and Board Chair Dr. Paul Berggreen (paul.berggreen@aimpa.us; 602-421-2408) if AIMPA can be of further assistance.

Sincerely,

Dr. Paul Berggreen
AIMPA President and Board Chair

Dr. Jack Feltz
AIMPA Chair, Federal Health Policy