AIMPA®

American Independent
Medical Practice
Association®

August 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: OPPS & ASC Proposed Rule (CMS-1850-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") OPPS and ASC Proposed Rule for Calendar Year 2027 (CMS-1850-P) ("Proposed Rule").[1] In many respects, the Proposed Rule takes meaningful steps toward resolving long-standing structural payment issues that have accelerated hospital consolidation of physician practices and, in turn, unnecessarily driven up the cost of care for Medicare beneficiaries. Just as importantly, the Proposed Rule promotes the independent clinical judgment of physicians in determining the most appropriate care setting for their patients, without financially penalizing beneficiaries for that choice. Our comments accordingly focus on those aspects of the Proposed Rule that will advance these goals for Medicare beneficiaries and for 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

[1] 91 Fed. Reg. 41734 (July 7, 2026).

exclusively to promoting and protecting high quality, cost-efficient care furnished to patients in independent medical practices. AIMPA represents more than 2,000 independent medical practices in 48 States. These practices include over 14,000 physicians who provide high-quality, affordable health care for approximately 40 million patients each year.

Our comments focus on three issues of great importance to the Medicare program and its beneficiaries:

- First, we support and urge CMS to finalize its proposal to extend site-neutral payment to imaging without contrast services, and we encourage CMS to expand its site-neutral payment policy to additional categories of services so that the historic site-of-care payment differential no longer drives beneficiaries into higher-cost care settings;

- Second, we support CMS's continued phase-out of the Inpatient Only Procedures ("IPO") list and the corresponding expansion of the ASC Covered Procedures List ("ASC CPL"), which will expand beneficiaries' access to high-quality, affordable care while respecting the independent clinical judgment of physicians in determining the most appropriate care setting; and

- Third, we urge CMS to finalize its proposal to pay average sales price ("ASP") minus 33.4 percent for 340B acquired drugs, and to work with the White House and Congress on statutory reforms that would eliminate the budget neutrality requirements constraining CMS's ability to reallocate savings from the 340B program toward the PFS and the ASC Payment System and, at the same time, eliminate the ASC weight scalar to promote care delivery in the more affordable independent practice and ASC settings.

As CMS finalizes the Proposed Rule, we encourage the agency to continue evaluating opportunities to improve healthcare affordability for Medicare beneficiaries and to promote competition across sites of care. By addressing payment disparities that have historically driven care into higher-cost settings and fueled hospital acquisition of physician practices, we believe CMS can advance healthcare reform that benefits the Medicare program, taxpayers, and beneficiaries.

I. CMS should finalize its proposal to apply site-neutral payment to imaging without contrast services and expand its site-neutral payment policy to additional categories of services so that the historic site-of-care payment differential stops driving beneficiaries into higher cost care settings.

A. AIMPA agrees with CMS's proposal to extend site-neutral payment to imaging without contrast services.

Last year, we supported CMS's proposal to expand site-neutral payment to drug administration services,[2] an important second step[3] towards controlling "unnecessary volume increases both in terms of the number of covered outpatient department services furnished and the costs associated with those services."[4] We commend CMS for finalizing that prior proposal and for proposing for CY 2027 further efforts to improve healthcare affordability by expanding its site-neutral payment policy to imaging without contrast services. This proposal is one of the most consequential changes to Medicare payment in recent years that will save the Medicare system and beneficiaries billions of dollars over the next 10 years, and yet, it only scratches the surface of the transformational payment policies that CMS could be implementing through site-neutral payment reform.

CMS is right to be concerned that Medicare's bifurcated payment system has created financial incentives that drive beneficiaries into higher cost care settings when beneficiaries could receive the same care in a lower-cost setting.[5] As CMS knows, this practice "threatens to create a significant source of unnecessary spending both by Medicare beneficiaries in the form of unnecessarily high copayments and by Medicare in the form of unnecessarily high Medicare payments."[6] Both the scale of that payment differential and the market behavior it has produced confirm the need for CMS to finalize its site-neutral proposal in the Proposed Rule and to consider other additional services and procedures that are ripe for similar treatment.

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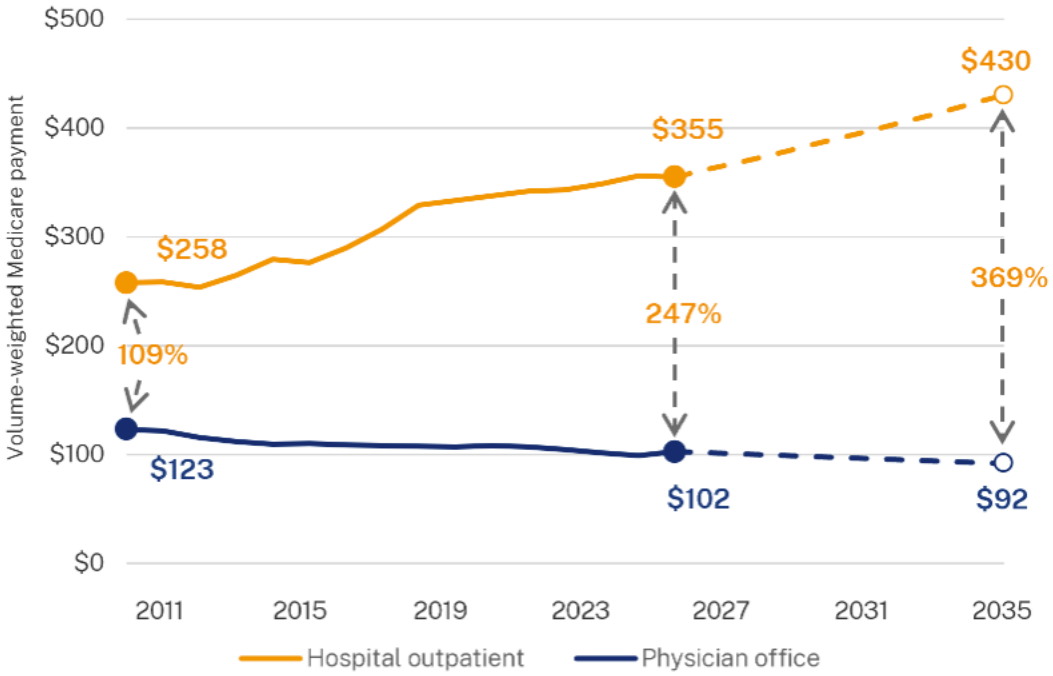
[2] AIMPA, *Comment Letter, OPPS/ASC Proposed Rule for CY 2026*, CMS-2025-0306-1961 (Sep. 11, 2025).
[3] In CY 2019, CMS "chose to start tackling this problem by addressing the clinic visit when provided in excepted PBDs." 90 Fed. Reg. 33476, 33686 (July 17, 2025).
[4] *Id.* at 33689.
[5] *See* 91 Fed. Reg. 41908 ("We continue to be concerned that beneficiaries are being driven into higher cost settings of care because of financial incentives when they could safely receive care in a lower cost setting").
[6] *Id.*

The magnitude of this financial incentive is staggering. In 2026, hospital outpatient departments ("HOPDs" or "OPDs") are projected to receive 247% greater payments than physician offices for the same services on a volume-weighted basis, more than double the 109% differential in 2011.[7] As shown in the chart below, if this trend continues, the gap is anticipated to reach 369% by 2035 for virtually indistinguishable services.[8]



Volume weighted Medicare payment
Source: Jackson Hammond & Atticus Vernacchio

That differential tells only half the story. Since 2001, HOPD payments (and the cost of operating a practice) have climbed, yet in the same period, Medicare physician payment declined by 33% when adjusted for inflation.[9] Independent medical practices are thus squeezed from both directions—paid materially less than HOPDs for identical services while absorbing cost increases their reimbursement does not cover—leaving them at an unsustainable competitive disadvantage.

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[7] Jackson Hammond & Atticus Vernacchio, *Medicare's Site-of-Service Payment Gap is Projected to Keep Growing*, Paragon Health Institute (July 21, 2026).
[8] *Id.*
[9] *Jan. 30, 2026: Medicare Payment Reform Advocacy Update*, American Medical Association (Jan. 30, 2026).

Hospitals, as CMS is aware, have responded predictably to the opportunity created by the bifurcated payment system, vertically consolidating the market by "purchasing freestanding physician practices and converting the billing from the PFS to the higher paying OPD visits."[10] The pace of that consolidation has been rapid. In 2012, approximately one in four physicians were employed by hospitals; as of January 2026, that share had more than doubled, to 59.7%.[11] In just the last two years, approximately 44,000 physicians became hospital employees, and that figure is expected to continue to grow.[12]

The growth of hospital employment of physicians is not a coincidence. 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 ("UPP") to a hospital-affiliated practice.[13] 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 procedures on a risk-adjusted basis.[14] 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.[15] 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.[16] As shown below, all other affiliation models across the four specialties studied had a far greater probability of providing care in the lower-cost setting (ASC or office):

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[10] 91 Fed. Reg. 41909.

[11] Physicians Advocacy Institute, *PAI-Avalere Health Report on Physician Employment Trends and Practice Acquisitions: 2018-2026* (April 2026).

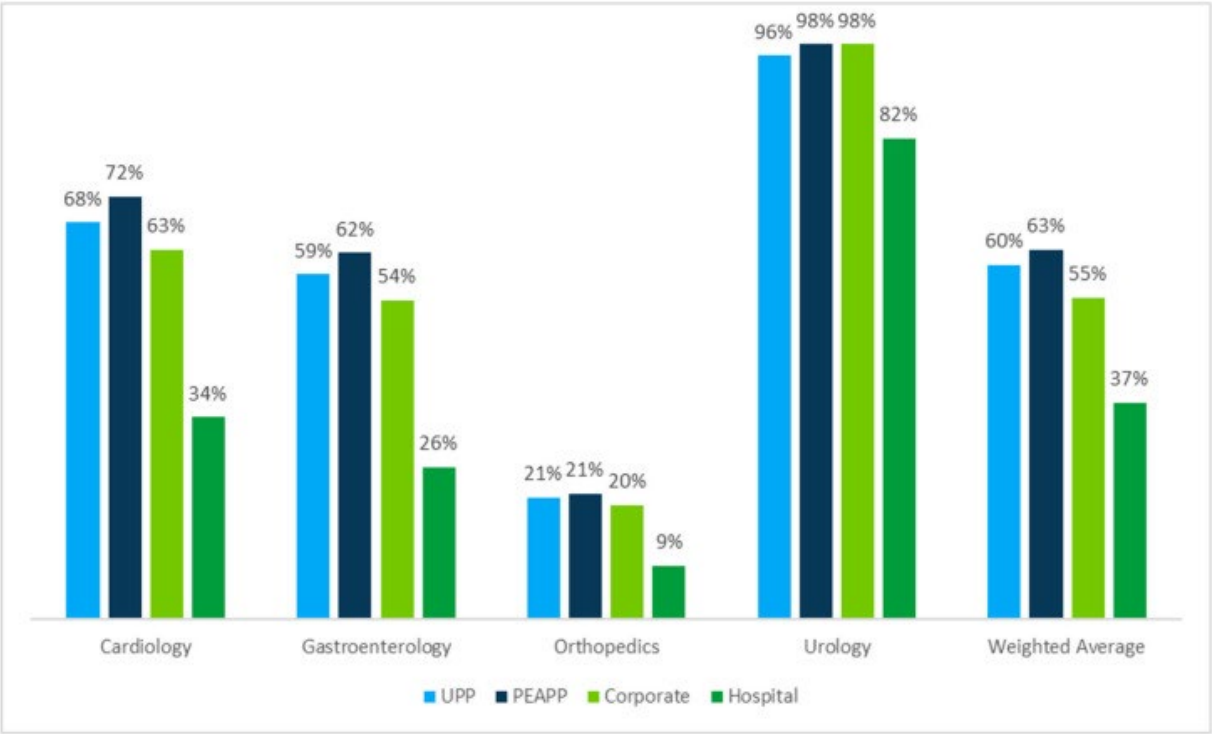
[12] *Id.*

[13] *Medicare Service Use and Expenditures Across Physician Practice Affiliation Models*, Avalere (Sep. 2024).

[14] Deepak Kapoor et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, J. Mkt. Access & Health Policy (2025) (examining the cost of care across sites of service for physicians practicing in the specialties of cardiology, gastroenterology, orthopedics, and urology).

[15] *Id.*

[16] *Id.*



Risk-adjusted probability of high volume procedures being provided in lower-cost settings, by specialty and affiliation model[17]
Source: Kapoor, et al.

This Administration—much like during President Trump's first term—recognizes the need to implement policies that will stop driving procedures and other services into the HOPD setting which, in turn, fuel hospital acquisitions of physician practices.[18] And CMS's proposal to extend the PFS-equivalent payment rate to imaging without contrast services[19] is a logical, incremental step in expanding the implementation of such a policy.

As CMS noted in the Proposed Rule, imaging without contrast services are "often high-volume, low-intensity services that can be provided in OPDs or freestanding offices," and that, "like with clinic visits, the difference in payment between OPDs and freestanding offices creates a strong incentive for providers to shift imaging without contrast services to the higher-cost setting."[20]

[17] "PEAPP" means private equity-affiliated private practice.
[18] 42 U.S.C. § 1395l(t)(2)(F)("[T]he Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services").
[19] Imaging without contrast APCs (5521 through 5524) and the related composite APCs 8004, 8005, and 8007.
[20] 91 Fed. Reg. 41909.

The 70 HCPCS codes that account for more than 95% of imaging without contrast volume in HOPDs (specifically, excepted provider based departments ("PBDs")) grew by over 38% from 2016 to 2025, driving a 33% increase in spending and approximately $126 million in additional spending in CY 2025 alone.[21] Utilization of these services per beneficiary increased by more than 67% over the same period, even as Part B fee-for-service beneficiary enrollment declined by approximately 17%. This divergence cannot be explained by population growth, strongly indicating that the site-of-care payment differential is leading to increased volume of imaging without contrast services.[22] There is also no clinical justification for this differential. According to a 2023 report, MedPAC found that all four imaging without contrast APCs (5521 through 5524) had higher volume in freestanding facilities than in HOPDs, demonstrating that these services can be, and routinely are, safely furnished in lower-cost settings.[23]

When CMS applied site-neutral payment to clinic visits during the first Trump Administration in 2019, volume at excepted PBDs fell by 25%, confirming that removing the payment differential curbs unnecessary volume without compromising access.[24] Finalizing the imaging without contrast proposal is estimated to save $260 million in CY 2027—$190 million for the Medicare program and $70 million for beneficiaries in the form of reduced coinsurance—and to lower net Part B spending by $7.2 billion from 2027 through 2036 on a non-budget-neutral basis.[25] Medicare beneficiaries will also benefit from these savings, with their 20 percent copay obligations reduced by approximately $1.44 billion over the same period. For these reasons, **we urge CMS to finalize its proposal to expand site neutral payment to imaging without contrast services**.

[21] *Id.*
[22] *Id.*
[23] *Report to the Congress: Medicare and the Health Care Delivery System*, Table 8-2, MedPAC (June 2023).
[24] 91 Fed. Reg. at 41914.
[25] *Id.* at 41916.

B. Consistent with its commitment to making health care more affordable for Medicare beneficiaries, CMS should accelerate site-neutral payment policy to cover additional categories of services.

In response to CMS's request for "other ways or other services for which we should exercise the Secretary's statutory authority under section 1833(t)(2)(F) of the Act,"[26] AIMPA proposes the following services, organized by specialty, that we believe are appropriate for similar site-neutral treatment:[27]

- *Cardiology*. While we commend CMS for its site neutrality proposal with respect to imaging without contrast services, there is no principled reason for CMS to distinguish between imaging with and without contrast when it comes to site-neutral payment policy. Imaging with and without contrast are equally safe in the office versus HOPD setting. The only difference is that Medicare and beneficiaries pay substantially more for the identical service when furnished in the HOPD setting. For example, nuclear stress tests (CPT code 78452) are reimbursed more than three times more in HOPDs than in the office setting.[28] Outside of imaging, loop-recorder insertion (CPT code 33285 (*Insertion, subcutaneous cardiac rhythm monitor, including programming*)) is a prime example of a brief subcutaneous procedure performed under local anesthesia that does not require catheterization lab or hospital resources, but that CMS pays substantially more for when performed in HOPDs.[29]

- *Gastroenterology*. As we stated in our comment letter last year, there is no justification for Medicare and beneficiaries paying two or three times as much when a colonoscopy or other endoscopic procedure is performed in an 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*

[26] *Id.* at 41917.

[27] For the services identified in Part I(B), we compare 2026 national average Medicare payments for HOPDs, ASCs, and physician offices (using the non-facility PFS price for physician offices). These figures reflect Medicare payments only and therefore understate the true payment disparity, which is even wider when the 20% beneficiary coinsurance obligation is included.

[28] HOPDs are paid $1,400 on average, whereas physician offices are paid $428.

[29] For CPT code 33285, HOPDs are paid $6,823 on average and physician offices are paid $4,012.

of tumor(s), polyp(s), or other lesion(s) by snare technique with polypectomy).[30]

- *Ophthalmology*. Minor eyelid procedures such as excisions of eyelid lesions (CPT code 67840) are commonly performed in physician offices under local anesthesia yet receive less than a third of the payment that HOPDs receive.[31] Site-neutral payment for these routine procedures would lower costs for beneficiaries and remove the incentive to shift care to higher-cost settings.

- *Orthopedic Surgery*. Joint injections (CPT codes 20610 and 20611) are frequently and safely performed in the office, however, HOPDs are reimbursed approximately two to four times more than physician offices for the same service.[32] Additionally, hand procedures such as trigger finger release (CPT code 26055), cyst removal (CPT code 26160), carpal tunnel release (CPT code 64721), and De Quervain release (CPT code 25000) can be performed safely in the office setting under local anesthesia, yet receive significantly greater reimbursement in HOPDs.[33]

- *Otolaryngology*. Submucous resection of inferior turbinate (CPT code 30140) is reimbursed 9.7x more in HOPDs than physician offices—despite being able to be safely performed in the office setting under local anesthesia.[34]

- *Urology*. Diagnostic cystourethroscopy (CPT code 52000) and prostate biopsies (CPT codes 55705-15) can be safely performed in ASCs—and in the even lower-cost office setting—yet Medicare pays approximately double

[30] 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 ($288) as compared to in an ASC ($175). Similar differentials exist with respect to Medicare beneficiaries' financial obligations for other endoscopic procedures: CPT code 43235 ($207 in HOPD vs. $121 in ASC); CPT code 43239 ($209 in HOPD vs. $123 in ASC); CPT code 45378 ($222 in HOPD vs. $134 in ASC); CPT code 45380 ($279 in HOPD vs. $166 in ASC).

[31] For CPT code 67840, physician offices are paid $278 on average, whereas HOPDs are paid $921.

[32] For CPT code 20610, HOPDs receive payments 4.1x greater than physician offices ($69 Office vs. $281 HOPD). For CPT code 20611, HOPDs receive payments 2.8x greater than physician offices ($104 Office vs. $290 HOPD).

[33] HOPDs are paid more than double for trigger finger release (CPT code 26055: $630 Office v. $1,544 HOPD) and cyst removal (CPT code 26160: $658 Office v. $1,560 HOPD) procedures. That disparity grows to roughly four to five times for carpal tunnel release (CPT code 64721: $483 Office v. $1,934 HOPD) and De Quervain release (CPT code 25000: $340 Office v. $1,586 HOPD) procedures.

[34] For CPT code 30140, HOPDs are paid $2,831 on average whereas physician offices are paid $293.

than allowed under the ASC Payment System if they are performed in HOPDs.[35]

These are but a few of the common procedures that can safely be performed outside of the HOPD setting and are appropriate for site-neutral treatment. We encourage CMS to continue its leadership in making healthcare more affordable by taking bold steps to accelerate the application of site-neutral payment policy across a broader array of procedures and other services. Doing so will reduce unnecessary costs for beneficiaries and taxpayers alike, while promoting a more competitive marketplace that rewards quality and efficiency over site-of-care.

II. AIMPA supports CMS's continued phase-out of the IPO list and expansion of the ASC CPL to ensure beneficiary access to high-quality care in more affordable care settings.

CMS's commitment to phasing out the IPO list will facilitate the delivery of more affordable healthcare for millions of Americans. AIMPA supports finalizing the proposal to remove an additional 637 services from the IPO list[36] and adding 618 procedures to the ASC CPL.[37] The IPO list was originally created to restrict Medicare from "pay[ing] for procedures furnished as outpatient services…because performing these procedures on an outpatient basis was not safe or appropriate."[38] As CMS recognizes, the need for the IPO list has diminished since its creation in 2000, because "new technologies and advances in surgical techniques and surgical care protocols…have reduced the inpatient length of stay and the need for postoperative care."[39]

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[35] HOPD payments are nearly double those under the ASC Payment System for these same procedures. *See* CPT code 52000 ($304 ASC vs. $625 HOPD); CPT code 55705 ($1,457 ASC vs. $2,960 HOPD); CPT code 55706 ($1,540 ASC vs. $3,043 HOPD); CPT code 55707 ($1,487 ASC vs. $2,990 HOPD); CPT code 55708 ($1,513 ASC vs. $3,016 HOPD); CPT code 55709 ($1,508 ASC vs. $3,011 HOPD); CPT code 55710 ($1,528 ASC vs. $3,031 HOPD); CPT code 55711 ($1,486 ASC vs. $2,989 HOPD); CPT code 55712 ($1,504 ASC vs. $3,007 HOPD); CPT code 55713 ($2,331 ASC vs. $4,530 HOPD); CPT code 55714 ($2,318 ASC vs. $4,517 HOPD). Note, CPT code 55715 also falls into this family of procedures but cannot be billed on its own, therefore, a direct comparison between the two sites of care cannot be made as readily.

[36] 91 Fed. Reg. at 41907.

[37] *Id.* at 41946.

[38] *Id.* at 41906.

[39] *Id.*

Migration of procedures from the IPO list to the ASC CPL promotes physicians' clinical autonomy by relying upon their judgment "to determine on a patient-by-patient basis whether or not a particular procedure would be most appropriately performed in the inpatient setting."[40] This empowers physicians to be better stewards of Medicare resources by referring beneficiaries to outpatient sites of care when clinically appropriate—care CMS recognizes will cost "less than the cost to provide the service in the inpatient setting."[41] Beneficiaries will also benefit from greater access to timely surgical services at additional facilities beyond just hospitals.[42]

These proposals will also help address CMS's previously noted concern that vertical consolidation by hospitals has increased healthcare costs through the unnecessary concentration of care in higher-cost settings. Although the IPO list once helped protect beneficiaries from unsafe care, it now risks forcing procedures into the higher-cost inpatient setting when outpatient care in an ASC would be equally safe and appropriate. Continuing to use the IPO list when the same care could be provided in an ASC would inappropriately remunerate hospitals simply because of their status as the sole reimbursable site-of-care. Such unnecessary payments make it harder for independent physician practices to compete, increasing their susceptibility to hospital consolidation. This in turn makes physicians substantially less likely to be able to provide care in lower-cost ASCs, compounding the cost problem.[43]

Accordingly, we support the proposals to remove 637 procedures from the IPO list and to add 618 procedures to the ASC CPL. We also encourage CMS to complete its proposed three-year phase-out of the IPO list in the proposed rule for CY 2028.

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[40] *Id.*
[41] *Id.* at 41907.
[42] *See* Elizabeth Munnich & Stephen Parente, *Returns to specialization: Evidence from the outpatient surgery market*, 57 J. Health Econ. 147 (2022) (Finding that patients treated in an ASC are less likely to be admitted to a hospital or visit an emergency room a short time after outpatient surgery).
[43] Kapoor et al., *supra* note 14.

III. AIMPA urges CMS to finalize its proposal to pay ASP minus 33.4 percent for 340B acquired drugs and work with Congress and the White House to eliminate certain budget neutrality requirements that constrain CMS's ability to make healthcare more affordable.

A. CMS should finalize its proposal to pay ASP minus 33.4 percent for 340B acquired drugs, saving the Medicare program and its beneficiaries billions of dollars.

In our comments to the Proposed Rule for the CY 2026 OPPS/ASC Payment System,[44] we urged CMS to complete the survey of hospitals' acquisition costs for outpatient drugs under the 340B program consistent with the Supreme Court's 2022 decision in *AHA v. Becerra*.[45] AIMPA commends CMS for taking this step after the prior Administration had failed to do so, and we support finalizing the proposed rule to pay ASP minus 33.4 percent for 340B acquired drugs.[46]

We appreciate CMS's leadership on this issue, despite a concerted effort by certain 340B hospitals to obstruct the very survey that the Supreme Court ruled was a prerequisite for CMS setting different payment rates for 340B and non-340B hospitals.[47] Their resistance was telling. As we explained in our comment letter last year, the 340B program has become a vehicle for certain hospitals to pad their margins and finance the acquisition of independent physician practices. Hospitals have made billions off the flawed 340B payment system, and patients have suffered. For example, for at least one drug, Lupron Depot, the acquisition cost survey showed that in some cases a "beneficiary's copay would be over $300 above the average hospital's 340B acquisition cost."[48] Under the Proposed Rule, by adjusting the payment rate to ASP minus 33.4 percent for CY 2027, "beneficiary copayments are estimated to be reduced by an estimated $1.15 billion."[49] This substantial cost savings will help beneficiaries reduce their out-of-pocket healthcare expenses and chip away at the surplus payments that hospitals have used to subsidize consolidation.

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[44] AIMPA, *supra* note 2.
[45] 596 U.S. 724 (2022).
[46] 91 Fed. Reg. 41887.
[47] *Id.* at 41880 ("We received a number of responses, many of which appeared to be coordinated form letters, from eligible hospitals indicating that they would not be providing their acquisition data and explaining their reasons for not doing so").
[48] *Id.* at 41890.
[49] *Id.* at 41891, 41895.

CMS's proposal reflects the data-driven approach required by *AHA v. Becerra* to right-size 340B payments to participating hospitals. The survey confirmed what GAO,[50] HHS-OIG,[51] CMS,[52] and others knew: that ASP plus 6 percent is not an appropriate payment proxy for hospitals acquiring drugs through the 340B Program. By adjusting the payment rate to ASP minus 33.4 percent, for CY 2027, "OPPS payments for 340B acquired drugs will be reduced by approximately $4.85 billion"—a considerable savings opportunity if budget neutrality requirements did not reallocate those payments within OPPS for non-drug payments.

We strongly support CMS's proposal to finalize the payment rate of ASP minus 33.4 percent for 340B acquired drugs in CY 2027. This data-driven approach faithfully implements the Supreme Court's decision in *AHA v. Becerra* and has the potential to deliver meaningful savings to Medicare beneficiaries.

B. CMS should work with the White House and Congress to enact legislation granting CMS flexibility to re-allocate savings from the 340B program in a manner that promotes healthcare affordability and, at the same time, eliminate the ASC Weight Scalar.

Although we support CMS's proposal to reset payment for 340B-acquired drugs at ASP minus 33.4 percent and eliminate the unnecessary surplus that the 340B program has historically given to hospitals, current statutory constraints limit CMS's ability to allocate the savings from this Proposed Rule towards payment systems that make healthcare more affordable. Specifically, OPPS's budget neutrality requirements[53] mandate that the estimated $4.85 billion reduction in 340B drug payments be reallocated to non-drug payments under the OPPS. In practice, for 340B hospitals, this means the financial windfall they had grown

[50] U.S. Gov't Accountability Off., GAO-15-442, MEDICARE PART B DRUGS: ACTION NEEDED TO REDUCE FINANCIAL INCENTIVES TO PRESCRIBE 340B DRUGS AT PARTICIPATING HOSPITALS 8 (June 2015) ("The amount of the 340B discount ranges from an estimated 20 to 50 percent off what the entity would have otherwise paid").

[51] HHS-OIG, OEI-12-14-00030, PART B PAYMENTS FOR 340B-PURCHASED DRUGS 9 (Nov. 2015) ("Part B paid covered entities a total of $1.3 billion (58 percent) more than the cost of the drugs").

[52] Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 83 Fed. Reg. 58818, 59018 (Nov. 21, 2018) ("we share the commenter's concern that current Medicare payments for drugs acquired by nonexcepted off-campus PBDs are well in excess of the overhead and acquisition costs for drugs purchased under the 340B Program").

[53] 42 U.S.C. 1395l(t)(9)(B), (t)(14)(H).

accustomed to will merely transfer to hospitals' reimbursement for non-drug services—effectively changing the cash register from which they collect the same payment. Hospitals will still be able to aggregate the financial resources necessary to acquire independent physician practices and further consolidate the healthcare market. Without a statutory fix, CMS lacks authority to allocate these savings to the historically under-resourced PFS, which—as we showed in Part I above—has resulted in a 33 percent decrease in physician reimbursement, on an inflation-adjusted basis, over the last 25 years.[54] This payment flaw in the Medicare program is making it impossible for independent practices to remain a viable competitive counterbalance to the higher-cost hospital outpatient setting.

The statutory requirement that the ASC Payment System be independently budget neutral[55] poses similar problems. CMS clearly wants to stop vertical consolidation from driving care into higher-cost settings. However, because CMS has taken the position that the ASC Payment System must be independently budget neutral, CMS has been unwilling to increase payments in a way that would incentivize the transition of clinically appropriate care to lower-cost ASCs. The payment differential between the OPPS and ASC Payment Systems continues to favor procedures performed in HOPDs, and therefore, the potential savings created by shifting procedures from the higher-cost inpatient setting to lower-cost ASCs cannot be fully realized without further action. Despite other efforts CMS is making in the Proposed Rule to shift care into a more affordable care setting, a significant number of the highest volume procedures in ASCs are poised for reimbursement cuts in 2027, due in part to CMS applying an independent budget neutrality requirement to the ASC payment system.

The ASC weight scalar is the methodological tool that CMS created to make the ASC Payment System independently budget neutral. CMS's application of a separate ASC weight scalar undercuts the Agency's efforts to save the Medicare program and beneficiaries billions of dollars by eliminating the IPO list and expanding the ASC CPL to promote competition, improve access, and make healthcare more affordable. Accordingly, we encourage CMS to exercise its authority to eliminate the ASC weight scalar or, at the very least, work with the White House and Congress to remove the independent budget neutrality requirement for the ASC Payment System—and thus the ASC weight scalar—via legislation so that CMS can more

[54] AMA, *supra* note 9.
[55] 42 USC § 1395l(i)(2)(D)(ii).

efficiently and effectively make health care more affordable for millions of Americans.

For these reasons, we encourage CMS to work with the White House and Congress on statutory reforms that would allow CMS to allocate savings from 340B to pay for needed inflation adjustments to the PFS and ASC Payment System and, at the same time, eliminate the ASC weight scalar.

IV. Request for Action.

We thank CMS for its efforts to expand access to high-quality, affordable care for millions of Americans. 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 extend site-neutral payment to imaging without contrast services, and expand site-neutral payment policy to additional categories of services, so that the historic site-of-care payment differential no longer drives beneficiaries into higher-cost care settings;

- Finalize the proposals to remove 637 procedures from the IPO list and add 618 procedures to the ASC CPL, and complete the proposed three-year phase-out of the IPO list in the proposed rule for CY 2028;

- Finalize the proposal to pay ASP minus 33.4 percent for 340B-acquired drugs; and

- Work with the White House and Congress on statutory reforms that would eliminate the budget neutrality requirements constraining CMS's ability to reallocate savings from the 340B program toward the PFS and the ASC Payment System and, at the same time, eliminate the ASC weight scalar to promote care delivery in the more affordable independent practice and ASC settings

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AIMPA stands ready to serve as a continued resource to CMS as you work to finalize the Proposed Rule. Please do not hesitate to reach out to AIMPA President, Dr. David Eagle (david.eagle@aimpa.us), if we can be of further assistance.

Sincerely,

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