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August 28, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Re: Medicare Program: Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems (CMS01850-P), Calendar Year 2027

Dear Administrator Oz:

On behalf of the Suburban Hospital Alliance of New York State, which represents hospitals and health systems on Long Island and in the Hudson Valley, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) hospital outpatient prospective payment system and ambulatory surgical center payment system (OPPS) proposed rule for calendar year (CY) 2027.

We offer comment on the proposed payment update, as well as proposals to accelerate recoupment of 340B funds, reduce the reimbursement rate for drugs acquired under the 340B program, expand site-neutral payment policy, and implement a statutory requirement for unique National Provider Identifiers (NPI) and attestations of compliance for all off-campus hospital outpatient departments (HOPD).

Payment Update

CMS proposes an inadequate market basket update of 2.4 percent for CY 2027 that fails to recognize the extraordinary inflationary pressures facing hospitals that sharply exceed the general rate of inflation in the economy. In our most recent statewide survey New York hospitals reported that, for the period of 2022 through 2025, their total labor expenses increased 23 percent, pharmaceuticals by 71 percent, supplies by 25 percent and energy by 15 percent, while OPPS payments have increased by only 10.7 percent over the same period. Hospitals also must prepare for significant funding reductions and increases in uncompensated care as H.R. is fully implemented. The proposed FY2027 update, compounded by years of inadequate rate adjustments, will further widen the gap between the cost of providing care and reimbursement.

Compounding the impact of an inadequate marketbasket increase for CY2027 is another unusually large productivity adjustment. Under the Affordable Care Act (ACA), the payment update is reduced annually by a productivity factor that is equal to the 10-year rolling average of changes in annual economy-wide, private nonfarm business total factor productivity (TFP). This assumes that healthcare facilities achieve efficiencies on par with non-healthcare sectors of the economy, which is not the case. Unlike other businesses, hospitals are required

to maintain excess capacity and workforce 24/7, so they have the ability to respond to traumas, mass casualty incidents and infectious disease outbreaks. Ongoing workforce shortages, leading to high rates of contract labor use and staff turnover, have further eroded productivity.

We urge CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for CY 2027 but, failing that, to seek out more refined data sources for the measurement of health system productivity.

Proposed Reimbursement Cut to Drugs Purchased under the 340B Program
CMS proposes to cut reimbursement rates for drugs acquired under the 340B Program by nearly 40 percent, from the current Average Sales Price (ASP) +6% rate to an alarming ASP -3.4%. The proposed cut is based upon the results of the recent OPPS Drug Acquisition Cost Survey (ODACS).

We share the concerns expressed by our colleagues at the Healthcare Association of New York State (HANYS) and American Hospital Association (AHA) on this matter. CMS has failed to demonstrate that its proposal meets both tests of the statute: that the ODACS results be of sufficient sample size as to produce a statistically significant estimate of drug acquisition cost, and that CMS collect this data for each covered outpatient drug. The survey response rate was far from robust, with only 28.6 percent of 340B hospitals responding. It also appears that CMS is relying upon an aggregate margin across all eligible drugs, not at the individual drug level required by statute.

CMS should not proceed with a nearly 40 percent payment reduction based on data that are insufficiently representative and extrapolated in a manner inconsistent with the statute.

The proposed cut will have a devastating impact on hospitals serving our most vulnerable communities. For many institutions, 340B program savings is the difference between operating in the red or in the black. It allows these hospitals to sustain much-needed programs and services, like drug discounts for patients, community health outreach programs, and continuation of clinical services like behavioral health and labor/delivery, that otherwise would not be feasible.

These consequences alone should trouble CMS. But this proposal does not exist in a vacuum. The Department of Health and Human Services recently has made a series of policy decisions that impose other significant costs on 340B hospitals. For example, HHS is pursuing a misguided Rebate Program that will inflict massive administrative costs, "float costs," and non-economic burdens on 340B hospitals. As the AHA has explained, the Rebate Program will cost 340B hospitals more than a billion dollars annually. The agency also is allowing Eli Lilly and other drug companies to impose unlawful, onerous, and expensive claims data requirements on hospitals, just so that they can receive discounts they already are owed by statute. CMS must weigh the cumulative effects of these policy choices before moving forward with this 40 percent reimbursement reduction.

Simply put, the proposed 40 percent cut will seriously harm New York's hospitals and health systems. CMS must account for these harms when weighing whether to finalize such a drastic

reduction in reimbursement rates. Nothing requires the agency to make this cut now. It should not do so.

340B Budget Neutrality Adjustment
CMS also proposes to increase the annual reduction to the OPPS conversion factor under §419.32(b)(1)(iv)(B)(12)—which the agency promulgated as a remedy after the Supreme Court's unanimous decision in *American Hospital Association v. Becerra*—from 0.5 to 3 percent annually. Like the proposed reimbursement cuts discussed above, nothing in the law requires this. In fact, the American Hospital Association has correctly explained in the past why any recoupment on any timeline is unlawful. However, for present purposes, **we must reiterate how harmful this accelerated clawback would be for Suburban Hospital Alliance members and urge CMS to abandon this proposal.**

Ultimately, hospitals should not be made to bear the consequences of CMS' unlawful reimbursement cut. Hospitals now subject to the clawback could not have declined any additional payments even if they had wanted to. Hospitals should not be punished for CMS' mistakes—many years after the fact — by having to return funds that they have long since spent, at a time when their finances are already being squeezed by rising costs, inadequate Medicare and Medicaid reimbursement, and other federal policy decisions.

Site-Neutral Payment Policy Expansion to Imaging Services
Suburban Hospital Alliance opposes CMS' proposal to reduce the payment to the "Physician Fee Schedule (PFS)-equivalent" rate of 40 percent of the OPPS rate for imaging services without contrast furnished in excepted HOPDs. **We urge the agency to withdraw this proposal from consideration.**

In particular, CMS did not consider other reasonable explanations for the increase in the volume of imaging without contrast services in HOPDs. We disagree that higher payments for these imaging services in HOPDs are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." This assertion ignores many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from Medicare, Medicaid and private payers, the cost of acquiring and maintaining electronic health records, and excessive administrative burdens.[1,2,3]

CMS also does not sufficiently demonstrate that its comparison of Ambulatory Payment Classifications payments to PFS payments provides an appropriate basis for imposing site-neutral payment reductions. CMS cites payment differences between HOPDs and physician office settings to support its proposal. However, comparing rates for these services does not accurately capture differences in resource use, total spending, beneficiary cost sharing or obligations associated with furnishing care in each setting. Specifically, outpatient PPS payments are based on hospital cost data that are submitted annually and include packaged items, services, supplies and supportive resources needed to furnish outpatient care. By contrast, PFS rates are based on relative value units (RVUs) for physician work, practice expense and malpractice expense, which are determined in part using survey data, the accuracy, representativeness and reliability of which

[1] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf
[2] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care
[3] https://www.aha.org/news/blog/2025-10-21-physician-practice-acquisitions-what-drives-them-and-implications-consumers-and-payers

has been questions by CMS itself. The calculation of PFS rates is not designed to reflect the broader operational, regulatory, staffing, standby-capacity and infrastructure requirements of HOPDs.

Thus, comparing payment rates for a single imaging procedure across the two disparate systems does not provide a complete picture of relative resource use or total episode costs. CMS has not presented sufficient analysis showing that these payment differences reflect excess program spending rather than legitimate differences in patient complexity, service mix, emergency preparedness, compliance obligations, care coordination and hospital-based resources. The agency also did not take into consideration that HOPDs are more likely to serve Medicare patients who are sicker, more clinically complex, and more likely to be disabled or living in poorer, rural communities than patients treated in independent physician offices.[4,5]

National Provider Identifier (NPI) for Off-Campus Provider-Based Departments
Under a provision of the Consolidated Appropriations Act of 2026, beginning Jan. 1, 2028, each off-campus HOPD will be required to obtain and bill under its own NPI, along with meeting new initial and subsequent provider-based attestation requirements. **We support many of CMS' proposals that would reduce burden for the attestation process. That said, we have significant concerns about the increased burden this will cause for hospitals and health systems, physicians and other insurers.** Specifically, we are concerned that, while required under the law, a separate NPI would substantially and negatively impact hospitals and health systems and their patients.

This separate NPI requirement raises several serious concerns:

- Inconsistent NPI use across insurers would undermine HIPAA's administrative simplification goal of a single provider identifier for all claims.
- Requiring different NPIs for different payers would disrupt coordination of benefits and prevent the same claim from being adjudicated across plans.
- Separate NPIs for each off-campus HOPD could add burden to physicians' and other professionals' claims submitted on the HIPAA standard professional claim.
- Because prior authorizations are often tied to a hospital NPI, different NPIs for the main campus and off-campus HOPDs could require separate approvals, delaying care when patients receive services across locations.
- Separate NPIs could also jeopardize split billing, preventing hospitals from combining services across HOPDs into one claim. This will increase patient cost-sharing and billing complexity.

To prevent greatly increasing hospital regulatory burden and patient billing confusion, we encourage CMS to take the following steps:

- Establish a phased-in and transparent implementation process.
- Provide sufficient time for provider enrollment changes, payer configuration and end-to-end testing.

[4] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025
[5] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

- Issue additional guidance to both providers and health insurers to prevent needless amplification of administrative difficulty and potential delays in patient care and to ensure that all parties involved are adequately prepared.
- Exercise enforcement discretion during this transition period for providers.
- Create a standardized mechanism that links each off-campus NPI to the hospital's main campus NPI and ensure this crosswalk is available to Medicare contractors and other payers so that systems can recognize the same hospital organization.
- Convene stakeholders to identify and resolve claims processing issues.

Thank you again for the opportunity to comment. If you have any questions, please do not hesitate to contact me.

Sincerely,

/s/*Wendy D. Darwell*

Wendy D. Darwell
President and CEO