

Ten Generic Hospital and Health System Comment Letters

CY 2027 OPPS/ASC Proposed Rule (CMS-1850-P)

Primary focus: proposed 340B payment reductions and cumulative hospital impact

Public comment deadline: August 31, 2026

Customization note

Replace bracketed fields with organization-specific facts, local examples, estimated financial impact, service lines at risk, and signatories. Each letter is designed to stand alone and may be submitted separately.

The letters cite page ranges from the public-inspection PDF of the proposed rule. Confirm final Federal Register page citations and any updated regulatory text before submission.

Letter themes

1. Protecting 340B Resources That Sustain Community Care
2. The 340B Survey Does Not Support a National ASP-Minus-33.4% Rate
3. Cumulative 340B and Remedy-Offset Reductions Threaten Hospital Stability
4. Preserving Oncology and Infusion Access Under the 340B Program
5. The Proposed Rule Disproportionately Harms Major Teaching Hospitals
6. Site-Neutral Imaging Cuts Ignore Hospital Obligations and Local Access
7. Rapid Inpatient-Only List Elimination Creates Clinical and Operational Risk
8. Do Not Expand Prior Authorization While Reducing Clinical Resources
9. Overlapping Reporting Mandates Divert Resources From Patient Care
10. Comprehensive Request to Revise the CY 2027 OPPS Proposed Rule

Primary documents reviewed

[Strategic Health Care CY 2027 OPPS/ASC Proposed Rule Summary](#)

[CMS CY 2027 OPPS/ASC Proposed Rule - Public Inspection PDF](#)

LETTER 1: PROTECTING 340B RESOURCES THAT SUSTAIN COMMUNITY CARE

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Protecting 340B Resources That Sustain Community Care

Dear Administrator Oz:

On behalf of [HEALTH SYSTEM NAME], its governing board, hospital leadership, medical staff, and the patients and communities we serve, we submit these comments on the Calendar Year 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center proposed rule. We strongly support CMS efforts to improve affordability and protect Medicare beneficiaries. However, we are deeply concerned that the proposed 340B payment policy would achieve short-term federal savings by removing resources that hospitals use every day to sustain access, stabilize essential services, and care for patients who have nowhere else to turn.

The proposed payment of average sales price minus 33.4 percent for separately payable 340B-acquired drugs is the most damaging provision in the rule. CMS estimates that this policy would reduce OPPS drug payments by approximately \$4.85 billion in 2027. Although the rule would redistribute that amount through an estimated 8.44 percent increase to non-drug OPPS payments, the redistribution is not a meaningful safeguard for hospitals with significant oncology, infusion, specialty pharmacy, and other high-cost drug volume. Those hospitals would lose targeted drug revenue while the offset is spread broadly across the OPPS. The result is a transfer away from many of the very hospitals Congress made eligible for 340B because they serve disproportionate numbers of low-income and medically complex patients.

The 340B program exists to allow covered entities to stretch limited resources, reach more eligible patients, and provide more comprehensive services. In our health system, 340B resources are not an abstract margin. They support programs such as [CHARITY CARE/FINANCIAL ASSISTANCE], [BEHAVIORAL HEALTH], [MATERNAL HEALTH], [RURAL OR URBAN ACCESS CLINICS], [MEDICATION ASSISTANCE], [MOBILE OR COMMUNITY HEALTH], and [OTHER LOCAL SERVICES]. These programs often operate at a loss because they are essential to the community. Reducing the financial benefit associated with 340B drugs will force hospital boards to make choices among services that patients need but that ordinary reimbursement does not adequately support.

CMS's proposal also fails to recognize that acquiring a drug is only one component of safely delivering it. Hospitals must maintain pharmacists, pharmacy technicians, sterile compounding capacity, inventory controls, cybersecurity, medication safety systems, accreditation, cold-chain storage, compliance infrastructure, emergency readiness, and clinical teams capable of managing adverse reactions. The proposed rule declines to provide a distinct add-on for overhead and handling. Paying a national estimate of acquisition cost without separately recognizing these required capabilities treats the hospital as a pass-through purchasing agent rather than a regulated clinical enterprise accountable for the entire episode of care.

The proposed exemptions for rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals acknowledge that certain providers would be uniquely harmed. That same logic applies to many disproportionate share hospitals, urban safety-net hospitals, rural referral centers, teaching hospitals, and community hospitals serving medically underserved areas. A hospital's vulnerability should not be determined solely by whether it fits one narrow provider category. CMS should evaluate patient mix, uncompensated care, Medicaid volume, local alternatives, specialty service obligations, and community need.

We therefore request that CMS not finalize the ASP-minus-33.4-percent policy. CMS should maintain ASP plus 6 percent while it conducts a more representative survey and develops a methodology that recognizes drug-specific acquisition cost, pharmacy overhead, and the community-care purpose of 340B. At a minimum, CMS should delay implementation, expand exemptions and hardship protections, phase in any adjustment over multiple years, and establish a loss cap for hospitals with high 340B drug intensity.

We also urge CMS not to accelerate the separate 340B remedy offset from 0.5 percent to 3 percent in 2027. Imposing the new drug reduction while simultaneously accelerating a broad conversion-factor recoupment would compound the harm and make responsible budgeting nearly impossible. Maintaining the existing 0.5 percent schedule would be the least disruptive approach; CMS should not finalize a rate above the 2 percent alternative discussed in the rule.

Our shared objective should be affordable care that remains available. A policy that lowers a beneficiary's coinsurance but causes a hospital to curtail infusion access, close a clinic, reduce navigation services, or delay community investments does not advance that objective. We respectfully ask CMS to reconsider the proposed 340B reductions and preserve the resources that health systems use to care for their communities.

Sincerely,

[NAME], President and Chief Executive Officer

[NAME], Chair, Board of Trustees

[NAME], M.D., Chief Medical Officer

[HEALTH SYSTEM NAME]

[ADDRESS]

LETTER 2: THE 340B SURVEY DOES NOT SUPPORT A NATIONAL ASP-MINUS-33.4% RATE

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: The 340B Survey Does Not Support a National ASP-Minus-33.4% Rate

Dear Administrator Oz:

[HEALTH SYSTEM NAME] appreciates the opportunity to comment on CMS-1850-P. We write from the perspective of leaders directly responsible for pharmacy operations, clinical quality, medication safety, and stewardship of hospital resources. We are seriously concerned that CMS proposes to use a limited and nonrepresentative acquisition-cost survey to establish a sweeping national payment rate of ASP minus 33.4 percent for 340B-acquired drugs.

The survey methodology is not sufficiently reliable for a policy of this magnitude. CMS reports that approximately 41.4 percent of hospitals in the refined survey population responded with acquisition-cost information, while only approximately 28.6 percent of identified 340B hospitals submitted usable data. In other words, the proposed national adjustment for 340B hospitals is based on responses from fewer than three in ten hospitals in the relevant population. Statistical weighting cannot fully cure nonresponse bias when the reasons hospitals did not respond may be directly related to pharmacy systems, purchasing arrangements, data extraction limitations, drug mix, contract pharmacy structures, or operational complexity.

A single national percentage also masks enormous variation. Acquisition cost is not uniform across products, manufacturers, quarters, package sizes, shortage conditions, wholesaler arrangements, and classes of trade. A hospital's actual experience may differ materially from an aggregate mean. The proposal would nevertheless apply the same 33.4 percent reduction across separately payable drugs, biologicals, biosimilars, and certain radiopharmaceuticals. This creates a substantial risk of underpayment for particular drugs and for hospitals whose product mix was not adequately represented in the survey.

The proposal further assumes that a conservative acquisition-cost estimate may already account for overhead and that hospitals may negotiate additional discounts. That assumption is not an adequate payment methodology. The survey sought drug acquisition cost; it did not establish the full cost of purchasing, storing, preparing, dispensing, administering, monitoring, documenting, and complying with federal and state requirements. Hospital pharmacy costs include sterile compounding facilities, USP compliance, hazardous-drug protections, pharmacists and technicians, medication-use technology, inventory carrying costs, waste management, shortage mitigation, audit readiness, diversion prevention, and around-the-clock clinical support. These costs are not optional, and they do not disappear because the drug was purchased at a 340B price.

CMS should also consider the distortion created by using ASP as the benchmark for a uniform subtraction. ASP is a manufacturer-reported market average, while 340B ceiling prices and hospital acquisition costs can vary over time and by product. A national ASP-minus percentage may be administratively simple, but administrative simplicity does not justify payment below the reasonable cost of safely furnishing a service. The proposed rule itself discusses an alternative ASP-minus-28-percent methodology derived from ceiling-price and utilization data. The existence of materially different estimates underscores the uncertainty in the evidence base.

We recommend that CMS withdraw the proposed ASP-minus-33.4-percent rate and undertake a second, independently validated survey with a substantially higher response rate. CMS should provide hospitals with standardized extraction specifications, a longer reporting window, direct technical support, clear treatment of credits and rebates, and an opportunity to validate preliminary results. The agency should publish detailed methodology, response-bias testing, product-level distributions, and sensitivity analyses before proposing a new rate.

If CMS proceeds with an acquisition-cost approach, it should use drug-specific or clinically coherent product-group rates rather than one national percentage; add an explicit payment component for pharmacy handling and overhead; establish an outlier or reconciliation process when payment falls below documented cost; protect drugs affected by

shortages or unusual acquisition conditions; and phase in the policy only after hospitals have received claim-level testing files and implementation guidance.

Finally, CMS should not pair an uncertain new 340B rate with a 3 percent acceleration of the remedy offset. The combination magnifies the consequences of any methodological error. The existing 0.5 percent offset should remain in place while CMS validates the survey and evaluates the cumulative effect on individual hospitals.

The clinical pharmacy enterprise is a patient-safety function, not merely a purchasing department. We urge CMS to develop a payment policy that is empirically sound, transparent, reproducible, and sufficient to support the infrastructure required to deliver complex medications safely.

Sincerely,

[NAME], Pharm.D., Chief Pharmacy Officer

[NAME], Chief Financial Officer

[NAME], M.D., Physician Executive for Ambulatory Services

[HEALTH SYSTEM NAME]

[ADDRESS]

LETTER 3: CUMULATIVE 340B AND REMEDY-OFFSET REDUCTIONS THREATEN HOSPITAL STABILITY

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Cumulative 340B and Remedy-Offset Reductions Threaten Hospital Stability

Dear Administrator Oz:

We submit these comments on behalf of [HEALTH SYSTEM NAME], a [NONPROFIT/GOVERNMENTAL] health system serving [SERVICE AREA]. Our concern is not limited to any single line item in the CY 2027 OPPS proposed rule. It is the cumulative financial effect of multiple policies that draw resources from hospitals at the same time, with the proposed 340B payment reduction representing the largest and most destabilizing component.

CMS proposes to reduce payment for 340B-acquired drugs from the generally applicable ASP-plus-6-percent methodology to ASP minus 33.4 percent. The agency estimates a \$4.85 billion reduction in 2027 drug payments and an 8.44 percent budget-neutral increase in non-drug OPPS rates. For an individual hospital, however, budget neutrality at the national level does not mean neutrality at the provider level. A hospital with a large share of expensive infusion, oncology, rheumatology, hematology, or specialty-drug services may lose far more in drug payment than it gains through the non-drug conversion factor.

CMS then proposes to accelerate the separate remedy-related conversion-factor reduction from 0.5 percent to 3 percent. The rule estimates that the 3 percent adjustment would recoup approximately \$2.3 billion in 2027 and complete the offset by the end of 2029. Thus, many hospitals would experience the new 340B drug reduction, the broad remedy offset, wage-index and APC changes, and other policy adjustments in the same year. Financial planning based on an average OPPS update obscures these concentrated losses.

Hospitals do not have the ability to instantaneously reduce fixed costs when Medicare payment changes. We maintain emergency departments, inpatient capacity, clinical laboratories, pharmacies, imaging equipment, cybersecurity, infection prevention, disaster preparedness, and specialty coverage regardless of daily volume. Our workforce contracts, capital financing, drug inventories, and technology commitments extend over multiple years. A large one-year payment shock must therefore be absorbed through delayed capital projects, reduced staffing growth, closure or consolidation of low-margin services, or diminished community-benefit spending.

The proposed redistribution is also inequitable. The 340B reduction is directed at a subset of covered entities, while the 8.44 percent non-drug increase is distributed across OPPS hospitals. Providers with little or no exposure to the drug reduction may receive significant increases, while high-340B hospitals may sustain net losses. CMS should not characterize this structure as protective merely because aggregate spending is held constant. It redistributes resources away from hospitals whose eligibility often reflects high levels of uncompensated care, Medicaid service, and care for vulnerable patients.

We request that CMS publish hospital-specific impact files that show the combined effect of the proposed 340B rate, the 8.44 percent conversion-factor increase, the remedy offset, site-neutral imaging reductions, wage-index changes, and other major provisions. Hospitals need sufficient detail to validate the assumptions and explain the effect to governing boards and communities. CMS should also conduct a distributional analysis by 340B eligibility type, drug intensity, teaching status, uncompensated-care burden, ownership, and geographic market.

Substantively, CMS should retain ASP plus 6 percent for 340B drugs in CY 2027. If the agency believes an acquisition-cost policy is required, it should delay implementation, cap annual losses, recognize pharmacy overhead, and create hardship exemptions for disproportionate share hospitals, rural referral centers, essential community hospitals, and providers with limited local alternatives. Any reduction should be phased in over at least three years and reconciled against actual product-level experience.

CMS should also maintain the remedy offset at 0.5 percent. The agency previously selected a long recoupment period to reduce disruption. No new evidence demonstrates that hospitals are now better positioned to absorb a six-fold acceleration. If CMS elects to shorten the schedule, the 2 percent alternative should be an absolute ceiling,

accompanied by a transition policy and an exclusion for hospitals sustaining a material net loss under the new 340B methodology.

Hospital financial stability is a prerequisite for patient access. We urge CMS to evaluate the combined policy package as a board and community would experience it: not as separate technical adjustments, but as simultaneous reductions that affect staffing, service lines, capital, and care. The final rule should avoid concentrated losses that compromise the ability of hospitals to fulfill their public mission.

Sincerely,

[NAME], Chief Financial Officer
[NAME], President and Chief Executive Officer
[HEALTH SYSTEM NAME]
[ADDRESS]

LETTER 4: PRESERVING ONCOLOGY AND INFUSION ACCESS UNDER THE 340B PROGRAM

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Preserving Oncology and Infusion Access Under the 340B Program

Dear Administrator Oz:

As physicians and hospital leaders responsible for cancer care, infusion services, pharmacy, nursing, and patient navigation at [HEALTH SYSTEM NAME], we write to express grave concern about the proposed payment of ASP minus 33.4 percent for 340B-acquired drugs. The policy would reduce the resources that make it possible for hospitals to provide coordinated, high-acuity outpatient drug therapy to Medicare beneficiaries and other patients in our community.

Hospital-based infusion care is not interchangeable with a simple drug purchase. Many patients treated in our departments are older, medically complex, immunocompromised, frail, or managing multiple chronic conditions. Their care requires oncology-trained nurses, pharmacists, emergency medications, laboratory support, rapid physician availability, infection-control infrastructure, medication reconciliation, toxicity monitoring, social work, financial counseling, and coordination with surgery, radiology, pathology, and inpatient services. These capabilities are present because the hospital maintains a complete clinical system, not because the acquisition price of a vial is high or low.

The proposed rule focuses on the difference between ASP and reported 340B acquisition cost, but it does not adequately account for the full cost or mission of the care environment. CMS expressly proposes no separate add-on for pharmacy overhead and handling. For oncology and other high-risk infusion therapies, that omission is especially consequential. Safe preparation and administration of hazardous drugs requires specialized facilities, personal protective equipment, closed-system processes, trained staff, waste controls, and continuous quality oversight. Medication shortages, dose changes, weight-based preparation, discarded amounts, and treatment delays create costs that are not captured by a national acquisition-cost percentage.

The proposed budget-neutral redistribution also does not preserve access. CMS estimates that 340B drug payments would decline by approximately \$4.85 billion, with an 8.44 percent increase applied to non-drug OPPS services. A hospital with a substantial oncology and infusion program may lose far more on drugs than it receives through unrelated non-drug services. The redistribution therefore disadvantages providers that have built the very clinical capacity Medicare beneficiaries rely upon for complex treatment.

In our community, 340B resources support [PATIENT NAVIGATION], [TRANSPORTATION], [FINANCIAL ASSISTANCE], [SCREENING], [CLINICAL PHARMACY], [RURAL OUTREACH], [LANGUAGE SERVICES], and [OTHER LOCAL PROGRAMS]. These services reduce missed treatments, identify adverse effects earlier, and help patients complete therapy. They are rarely fully reimbursed. A reduction in 340B resources will not remain confined to an accounting ledger; it will reach the patient through fewer navigators, longer travel, delayed appointments, reduced assistance, and less local access.

We recognize CMS's interest in reducing beneficiary coinsurance. That objective should be pursued directly and transparently rather than by removing resources from safety-net providers. CMS should explore beneficiary protections that do not destabilize the clinical delivery system, including targeted cost-sharing relief, manufacturer accountability, and payment models that separate patient liability from the hospital's ability to finance essential infrastructure.

We request that CMS withdraw the ASP-minus-33.4-percent proposal and continue ASP plus 6 percent for 340B-acquired drugs. If CMS proceeds, it should exempt oncology drugs, cellular and gene therapies, radiopharmaceuticals, drugs subject to shortage, and other high-risk specialty products until a product-specific cost methodology and explicit pharmacy-service payment are developed. CMS should also expand hospital exemptions, cap annual losses, and create an expedited exception process when local treatment access would otherwise be reduced.

The agency should not accelerate the 340B remedy offset to 3 percent at the same time. Hospital infusion programs need predictable resources to recruit nurses and pharmacists, maintain sterile compounding capacity, and schedule treatments without interruption. At minimum, CMS should retain the 0.5 percent offset and delay any new 340B rate for one year while it evaluates access implications by cancer type, geography, hospital category, and travel distance.

Patients should not be forced to choose between lower coinsurance and continued access to a trusted, clinically integrated treatment site. CMS can protect both affordability and access by preserving 340B resources and designing a more precise policy. We urge the agency to do so in the final rule.

Sincerely,

[NAME], M.D., Chief Medical Officer

[NAME], M.D., Chair, Department of Oncology/Hematology

[NAME], R.N., Chief Nursing Officer

[NAME], Pharm.D., Director of Oncology Pharmacy

[HEALTH SYSTEM NAME]

[ADDRESS]

LETTER 5: THE PROPOSED RULE DISPROPORTIONATELY HARMS MAJOR TEACHING HOSPITALS

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule
Subject: The Proposed Rule Disproportionately Harms Major Teaching Hospitals

Dear Administrator Oz:

[ACADEMIC HEALTH SYSTEM NAME] submits these comments on the CY 2027 OPPS/ASC proposed rule on behalf of our hospitals, faculty physicians, residents, fellows, nurses, pharmacists, researchers, and patients. We are particularly troubled by the proposed 340B payment reduction and its interaction with the rule's broader impact on major teaching hospitals.

CMS's own impact discussion estimates that major teaching hospitals would experience an average 2.4 percent decrease in OPPS payments, even though the stated OPD fee schedule increase factor is 2.4 percent. That reversal is a warning that national averages conceal substantial distributional effects. Major teaching hospitals care for patients referred from broad regions, operate advanced specialty programs, maintain trauma and transplant capacity, train the next generation of clinicians, and frequently serve as providers of last resort. Payment policy should not penalize the institutions carrying these responsibilities.

The proposed 340B rate of ASP minus 33.4 percent is the central concern. Academic medical centers often have high volumes of separately payable drugs because they treat cancer, autoimmune disease, blood disorders, rare disease, transplant patients, and complex infections. The proposed \$4.85 billion reduction in 340B drug payment, offset through an 8.44 percent increase in non-drug services across OPPS hospitals, is unlikely to be neutral for institutions with this clinical profile. The policy would transfer resources away from specialty care and teaching missions while rewarding providers with lower drug intensity.

340B resources help finance services that are integral to an academic safety-net mission but are not fully reflected in claims payment: multidisciplinary case conferences, clinical pharmacy, patient navigation, language access, social work, charity care, community-based prevention, training in underserved settings, and participation in complex care networks. These investments improve care for Medicare beneficiaries as well as the broader community. Reducing 340B resources weakens the infrastructure that supports quality and innovation.

The survey supporting the 33.4 percent adjustment also warrants caution. Only approximately 28.6 percent of identified 340B hospitals submitted usable acquisition-cost data. The nonresponding group may include large, operationally complex systems for which extracting and standardizing product-level acquisition data was most difficult. Applying weighted results to all 340B hospitals, including institutions with very different purchasing and clinical profiles, creates a significant risk of mismeasurement. CMS should not use a low-response survey to impose a uniform national payment reduction of this scale.

In addition, the proposal does not separately compensate hospitals for pharmacy overhead and handling. Academic centers maintain highly specialized sterile compounding, investigational pharmacy support, pharmacogenomics, medication safety, infectious-disease stewardship, and twenty-four-hour clinical pharmacy services. These costs are part of furnishing the drug and safeguarding the patient. A payment rate based primarily on estimated acquisition cost is incomplete.

We ask CMS to retain ASP plus 6 percent for 340B-acquired drugs and conduct a new survey with stronger participation, product-level analysis, independent validation, and explicit measurement of pharmacy-service costs. At a minimum, CMS should create an exemption or hold-harmless policy for major teaching hospitals, disproportionate share hospitals, transplant centers, and institutions that demonstrate a material net loss after the budget-neutral redistribution.

CMS should likewise reject the proposed 3 percent acceleration of the remedy offset. Major teaching hospitals should not face a new 340B reduction and an accelerated non-drug recoupment in the same year. Maintaining the 0.5 percent offset would reduce disruption; any alternative should be phased in and coordinated with the final 340B policy.

We also urge CMS to assess the rule's effect on physician training and specialty workforce supply. When payment reductions lead to constrained service lines, fewer outreach clinics, reduced faculty recruitment, or deferred technology, the effects extend beyond one payment year. They shape where clinicians train, which specialties remain available, and whether complex patients can receive care close to home.

CMS has emphasized superior outcomes and protection of vulnerable populations. Preserving the capacity of major teaching hospitals is essential to both goals. We respectfully request substantial revision of the proposed 340B policy and a comprehensive mitigation strategy for teaching hospitals before any final rule is issued.

Sincerely,

[NAME], President and Chief Executive Officer
[NAME], M.D., Dean, School of Medicine
[NAME], M.D., Chief Clinical Officer
[NAME], M.D., President, Medical Staff
[ACADEMIC HEALTH SYSTEM NAME]
[ADDRESS]

LETTER 6: SITE-NEUTRAL IMAGING CUTS IGNORE HOSPITAL OBLIGATIONS AND LOCAL ACCESS

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule
Subject: Site-Neutral Imaging Cuts Ignore Hospital Obligations and Local Access

Dear Administrator Oz:

[HEALTH SYSTEM NAME] urges CMS to reconsider two related policies in the CY 2027 OPPS proposed rule that would reduce resources available for community-based hospital care: the proposed 340B drug payment reduction and the expansion of site-neutral payment to imaging without contrast in excepted off-campus provider-based departments.

Our foremost concern is the proposal to pay 340B-acquired drugs at ASP minus 33.4 percent. The reduction would remove resources that support access across the hospital, including services located outside the main campus. The 8.44 percent budget-neutral increase in non-drug OPPS payments does not ensure that an individual 340B hospital will be made whole, particularly where specialty drug volume is high. The separate proposal to accelerate the remedy offset to 3 percent further compounds the loss.

Against that backdrop, CMS proposes to pay specified imaging without contrast services in excepted off-campus departments at a Physician Fee Schedule-equivalent amount. CMS estimates \$260 million in savings in 2027 and \$7.2 billion in net Part B savings from 2027 through 2036. Unlike the 340B adjustment, these imaging reductions would not be redistributed through OPPS budget neutrality. They are direct reductions in hospital resources.

CMS's analysis treats many imaging services as comparable across settings, but the service code does not capture the obligations of a hospital department. Provider-based departments are integrated into hospital quality systems, emergency preparedness, infection prevention, cybersecurity, accreditation, compliance, and medical staff oversight. They maintain equipment standards, technologist competencies, access to prior images, radiologist consultation, escalation pathways, and connectivity to emergency and inpatient care. They often accept patients whom freestanding centers cannot accommodate because of mobility limitations, implanted devices, behavioral needs, complex histories, or inability to pay.

Volume growth alone does not demonstrate unnecessary utilization. Growth may reflect population aging, expanded screening, physician practice integration, closure of independent sites, migration of services closer to patients, improved access, and shifts in Medicare enrollment. CMS should not infer inappropriate site shifting without examining market-level capacity, beneficiary travel, wait times, case mix, hours of operation, and whether a freestanding alternative actually accepts the patient.

The proposed exemption for rural sole community hospitals appropriately recognizes that some communities cannot absorb the loss of hospital outpatient access. The same concern applies to many urban and suburban underserved areas, rural referral regions, and communities with limited public transportation or high rates of chronic disease. A narrow provider-category exemption will miss hospitals that are functionally essential but do not meet the technical definition of a rural sole community hospital.

We request that CMS not finalize the site-neutral imaging proposal for CY 2027. The agency should first conduct a market-level access analysis and develop exemptions for hospitals serving health professional shortage areas, medically underserved areas, high Medicaid or uncompensated-care populations, and communities with no reasonable alternative imaging capacity. At minimum, CMS should use a partial relativity adjustment rather than the full Physician Fee Schedule-equivalent reduction, phase the change in over several years, and establish a hardship exception based on access and financial impact.

CMS should also avoid layering the imaging reduction on hospitals experiencing a net loss from the 340B proposal. A combined-loss cap could prevent a single institution from facing destabilizing reductions across drugs, imaging, and the remedy offset. Hospital-specific impact files should separately show each policy and the cumulative effect by location.

Our radiologists support appropriate use and evidence-based imaging. We also know that patients need reliable local access to accredited services connected to their clinical record and care team. Payment policy should reward efficiency without presuming that hospital capabilities have no value. We urge CMS to preserve ASP-plus-6-percent payment for 340B drugs and withdraw or substantially narrow the site-neutral imaging proposal.

Sincerely,

[NAME], President and Chief Executive Officer
[NAME], Chief Operating Officer
[NAME], M.D., Chair, Department of Radiology
[HEALTH SYSTEM NAME]
[ADDRESS]

LETTER 7: RAPID INPATIENT-ONLY LIST ELIMINATION CREATES CLINICAL AND OPERATIONAL RISK

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Rapid Inpatient-Only List Elimination Creates Clinical and Operational Risk

Dear Administrator Oz:

We submit these comments as hospital and physician leaders responsible for surgical quality, anesthesia, utilization management, patient status, and discharge safety at [HEALTH SYSTEM NAME]. We ask CMS to reconsider the proposed 340B payment reduction and to pause the second phase of eliminating the inpatient-only list.

The 340B proposal is the largest threat to our capacity to absorb other operational changes in the rule. Paying 340B-acquired drugs at ASP minus 33.4 percent would reduce funds used to support clinical staffing, pharmacy services, care coordination, and uncompensated care. The proposed 8.44 percent non-drug redistribution is not provider-specific protection, and the simultaneous 3 percent remedy offset would further reduce non-drug payment. A hospital cannot safely redesign hundreds of surgical pathways while its clinical support resources are being materially reduced.

CMS proposes to remove 637 services from the inpatient-only list in CY 2027, approximately half of the 1,438 services remaining. We recognize that removal does not mandate outpatient performance and that physicians retain authority to determine the appropriate setting. In practice, however, large-scale removal changes audit exposure, patient-status expectations, utilization-review workflows, beneficiary notices, coding, and payer behavior. It also creates pressure to classify complex cases as outpatient even when the patient's comorbidities and post-procedure needs warrant inpatient care.

Clinical appropriateness depends on more than the procedure code. Age, frailty, cognitive status, anticoagulation, cardiopulmonary disease, renal function, home support, travel distance, anesthesia risk, expected blood loss, pain control, and the likelihood of conversion or complications all matter. A procedure that is safe as outpatient care for one beneficiary may require inpatient monitoring for another. The scale of the proposed list removal makes it difficult to build evidence-based criteria, educate clinicians, update order sets, revise case-management systems, and communicate with beneficiaries before January 1, 2027.

The proposal also risks confusion under the two-midnight framework. When a service is newly eligible for OPPS payment, hospitals must determine status prospectively under uncertain clinical conditions. Retrospective review can substitute hindsight for bedside judgment. Denials and reclassification consume physician and nurse time, delay billing, increase appeals, and may expose beneficiaries to unexpected cost-sharing or notice requirements.

We request that CMS reduce the scope of the CY 2027 removal and use a clinical risk-based process rather than eliminating approximately half of the remaining list in one year. CMS should convene specialty societies, anesthesiologists, hospitalists, surgeons, nurses, and patient representatives to identify procedures with mature outpatient evidence. Complex procedures should remain on the list until CMS has adequate claims, quality, and adverse-event data.

For procedures removed from the list, CMS should establish a multi-year exemption from certain medical-review denials when the physician documents patient-specific risk; require Medicare Advantage plans to apply equivalent transition protections; clarify beneficiary cost-sharing and notice rules; publish national clinical examples; and monitor emergency visits, readmissions, observation stays, transfers, and mortality before moving to the final phase.

CMS should also recognize the relationship between payment adequacy and safe transitions. 340B resources and OPPS payment support pharmacists, case managers, preoperative clinics, social workers, and post-discharge follow-up. Removing those resources while expanding outpatient eligibility for hundreds of services is inconsistent with patient-centered implementation.

Accordingly, we urge CMS to retain ASP plus 6 percent for 340B drugs, maintain the remedy offset at 0.5 percent, and substantially narrow or delay the proposed 637-service inpatient-only list removal. The final rule should protect physician judgment and give hospitals sufficient time and resources to implement clinically sound pathways.

Sincerely,

[NAME], M.D., Chief Medical Officer
[NAME], M.D., Chair, Department of Surgery
[NAME], M.D., Chair, Department of Anesthesiology
[NAME], R.N., Vice President for Care Management
[HEALTH SYSTEM NAME]
[ADDRESS]

LETTER 8: DO NOT EXPAND PRIOR AUTHORIZATION WHILE REDUCING CLINICAL RESOURCES

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule
Subject: Do Not Expand Prior Authorization While Reducing Clinical Resources

Dear Administrator Oz:

[HEALTH SYSTEM NAME] appreciates CMS's public commitment to reducing paperwork, accelerating electronic prior authorization, and putting patients ahead of administrative burden. We are therefore concerned that the CY 2027 OPPS proposed rule would expand prior authorization for additional botulinum toxin injection codes beginning July 1, 2027 while simultaneously reducing 340B resources that help hospitals staff and operate the affected clinics.

The proposed 340B payment rate of ASP minus 33.4 percent would reduce drug payment by an estimated \$4.85 billion nationally in 2027. For hospitals with neurology, rehabilitation, pain, oncology, and specialty infusion programs, the national 8.44 percent non-drug redistribution may not offset the drug loss. The proposed 3 percent remedy offset adds another reduction. These policies place clinical programs under financial strain at the same time CMS would require additional authorization work before care can be delivered.

Botulinum toxin is used for diverse, medically necessary conditions, including spasticity, dystonia, chronic migraine, blepharospasm, and other neurologic or rehabilitative indications. Patients often receive treatment on established intervals to preserve function, reduce pain, prevent contractures, support caregiving, and avoid more intensive services. Delays can result in loss of mobility, increased falls, emergency visits, missed work by caregivers, and deterioration that is not quickly reversed after authorization is finally obtained.

CMS cites utilization growth as a reason for review, but growth does not by itself establish inappropriate care. It may reflect broader evidence-based indications, improved diagnosis, an aging population, movement from more invasive therapies, or increased access to specialists. Before imposing prior authorization, CMS should identify the specific coding, provider, geographic, or clinical patterns associated with improper payment and use targeted education or review rather than a broad pre-service requirement.

The operational burden is substantial. A prior authorization request requires staff to locate and submit documentation before the service and claim. Clinics must track expiration dates, treatment cycles, dosage changes, laterality, prior response, payer-specific forms, and appeals. When a request is delayed, the appointment slot, drug inventory, physician schedule, and patient's transportation may all be disrupted. These costs are not fully recognized in the OPPS rate and will be harder to absorb under the proposed 340B reduction.

We request that CMS not finalize the additional botulinum toxin codes for prior authorization in 2027. CMS should first implement a fully electronic, standards-based process integrated with hospital electronic health records; publish clear, diagnosis-specific documentation criteria; test the workflow with clinicians; and demonstrate that decisions can be returned reliably within a clinically appropriate period.

If CMS proceeds, the final policy should include automatic approval for continuation therapy when prior sessions were covered and clinically effective; expedited review when delay risks functional decline; no prior authorization for urgent inpatient-to-outpatient continuation; multi-cycle authorizations for stable patients; protection against denial based solely on minor documentation omissions; a transparent peer-to-peer process with the same specialty; and public reporting of approval rates, turnaround times, and overturned denials.

CMS should also align the implementation date with functioning electronic interfaces and exempt providers that participate in low-denial or gold-card programs. The agency should not require hospitals to build duplicative portals or manual fax workflows.

Most importantly, CMS should retain ASP-plus-6-percent payment for 340B-acquired drugs and keep the remedy offset at 0.5 percent. Clinical programs cannot absorb both a major payment reduction and a new administrative mandate without consequences for staffing and access. Protecting Medicare beneficiaries requires timely treatment, adequate clinical resources, and payment policies that support rather than undermine those goals.

Sincerely,

[NAME], M.D., Chief Medical Officer

[NAME], M.D., Medical Director, Neurology/Movement Disorders

[NAME], M.D., Medical Director, Physical Medicine and Rehabilitation

[NAME], Vice President, Ambulatory Services

[HEALTH SYSTEM NAME]

[ADDRESS]

LETTER 9: OVERLAPPING REPORTING MANDATES DIVERT RESOURCES FROM PATIENT CARE

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Overlapping Reporting Mandates Divert Resources From Patient Care

Dear Administrator Oz:

We submit these comments on behalf of the leaders who must translate CMS policy into claims, enrollment records, clinical workflows, compliance controls, and public data at [HEALTH SYSTEM NAME]. The CY 2027 OPPS proposed rule would create overlapping implementation demands at the same time the proposed 340B payment reduction removes resources needed to carry them out.

The 340B proposal would require hospitals to distinguish claim-level payment through the JG, TB, and new XX modifiers across both excepted and nonexcepted off-campus departments. Because the modifier would directly determine whether payment is ASP minus 33.4 percent or another rate, errors could create overpayments, underpayments, audit exposure, and false-claims risk. Hospitals will need to modify purchasing feeds, drug master files, charge capture, billing edits, split-billing logic, audit protocols, and staff training. CMS should not underestimate the complexity of accurately connecting a particular drug unit on a claim to its acquisition pathway.

These new controls would be implemented while CMS also discusses separate NPIs and mandatory provider-based attestations for off-campus departments beginning in 2028. Each location may require enrollment changes, payer mapping, clearinghouse testing, EHR and scheduling updates, laboratory and pharmacy interface changes, claim-form revisions, and coordination with Medicare Advantage and commercial payers. Subsequent attestations, site visits, remote audits, and other verification mechanisms will require continuing documentation and governance.

The hospital price-transparency request for information presents another layer of complexity. We support giving patients accurate, actionable information. However, payer contracts often include stop-loss provisions, tiers, outliers, bundles, carve-outs, percentages, algorithms, and retrospective adjustments that cannot be reduced to one meaningful dollar amount. Requiring hospitals to create standardized figures from terms controlled jointly by payers and hospitals can produce data that appear precise but are misleading. Hospitals should not bear sole liability for information that depends on payer adjudication and claims history.

The cumulative burden matters. A health system has finite teams in revenue cycle, pharmacy informatics, compliance, finance, enrollment, and information technology. The same experts are also implementing interoperability, prior authorization, cybersecurity, quality reporting, cost-report changes, and other federal requirements. Every new modifier, attestation, file specification, and audit protocol competes with patient-care improvements and cybersecurity work.

The proposed 340B reduction intensifies this problem. CMS estimates \$4.85 billion less in 340B drug payment, redistributed through non-drug OPPS rates. Hospitals with significant 340B drug volume may experience a net loss even as their compliance responsibilities increase. The rule also proposes a 3 percent remedy offset. It is unreasonable to reduce the resources supporting compliance while materially expanding the number and consequence of required data elements.

We request that CMS retain ASP plus 6 percent for 340B drugs and, at minimum, delay any new modifier structure until hospitals have received complete technical specifications, test files, and a nonpunitive transition period. CMS should provide a good-faith safe harbor for modifier errors discovered through routine audit, permit corrected claims without penalty, and coordinate definitions across OPPS, Medicaid duplicate-discount requirements, and HRSA 340B oversight.

For off-campus departments, CMS should create a single electronic attestation process that prepopulates PECOS data, permits system-level submission, allows correction before payment denial, and avoids separate re-attestation when ownership and operations have not materially changed. CMS should publish implementation guidance at least twelve months before payment is conditioned on compliance.

For price transparency, CMS should require payers to provide standardized contract and remittance data, establish shared accountability, preserve the estimator-tool pathway, and test any new schema before mandating publication. Complex arrangements should be displayed with explanatory context rather than forced into a misleading single price. CMS can improve transparency and program integrity without creating avoidable administrative risk. We urge the agency to sequence these policies, simplify reporting, protect good-faith compliance, and preserve the 340B resources hospitals need to implement federal requirements responsibly.

Sincerely,

[NAME], Chief Compliance Officer
[NAME], Chief Information Officer
[NAME], Vice President, Revenue Cycle
[NAME], M.D., Physician Executive
[HEALTH SYSTEM NAME]
[ADDRESS]

LETTER 10: COMPREHENSIVE REQUEST TO REVISE THE CY 2027 OPPS PROPOSED RULE

August __, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1850-P; Docket CMS-2026-2344 - CY 2027 OPPS/ASC Proposed Rule

Subject: Comprehensive Request to Revise the CY 2027 OPPS Proposed Rule

Dear Administrator Oz:

The executive and physician leadership of [HEALTH SYSTEM NAME] respectfully submits this comment on CMS-1850-P. We share CMS's goals of affordability, integrity, transparency, and high-quality care. Yet the proposed rule combines payment reductions, site-neutral policies, utilization controls, and new administrative requirements in a manner that could weaken the hospital infrastructure Medicare beneficiaries depend upon. The proposed 340B policy is our most serious concern and should not be finalized.

First, CMS proposes to pay 340B-acquired drugs at ASP minus 33.4 percent based on a survey in which approximately 28.6 percent of identified 340B hospitals submitted usable acquisition-cost data. The policy would reduce 340B drug payments by an estimated \$4.85 billion in 2027. A low-response survey and a single national percentage are not a sufficient foundation for a change of this magnitude. The approach also omits a distinct payment for pharmacy overhead, handling, sterile preparation, inventory, compliance, and clinical medication management.

Second, the proposed 8.44 percent increase in non-drug OPPS payment does not make each affected hospital whole. It redistributes the reduction across OPPS providers, creating winners and losers based on service mix rather than community need. High-volume 340B hospitals may incur large net losses. Those losses will reduce the resources available for uncompensated care, medication assistance, behavioral health, maternal health, physician recruitment, rural and urban outreach, and other community services.

Third, CMS proposes to accelerate the separate 340B remedy offset from 0.5 percent to 3 percent, producing an estimated \$2.3 billion reduction in 2027. The agency should not impose a new acquisition-cost payment policy and a six-fold acceleration of the remedy offset simultaneously. The cumulative effect is more important than the description of either provision in isolation.

Fourth, the expansion of site-neutral payment to imaging without contrast in excepted off-campus departments would impose direct, non-budget-neutral reductions. Hospital departments carry accreditation, emergency preparedness, quality, integration, standby, compliance, and access obligations that physician offices and freestanding facilities may not share. CMS should not assume that identical codes represent identical patients, capabilities, or costs. Exemptions should extend beyond rural sole community hospitals to other essential and underserved providers.

Fifth, the proposal to remove 637 services from the inpatient-only list is too broad for one implementation year. Physicians need flexibility to select the appropriate setting based on patient-specific risk, and hospitals need time to revise pathways, status review, beneficiary notices, and coding. CMS should use a clinically staged process and provide transition protections against retrospective denials.

Sixth, adding botulinum toxin injection codes to prior authorization would create treatment delays and administrative work. CMS should not expand prior authorization until a fully electronic process is operating, continuation therapy receives streamlined approval, and clinical turnaround standards are enforceable.

Seventh, off-campus NPI and attestation requirements, claim modifiers, price-transparency changes, and audits will demand substantial information-technology and compliance work. These requirements should be harmonized, tested, phased, and supported by good-faith safe harbors. CMS should require shared payer accountability for price data and avoid duplicative location-by-location submissions when system-level information is available.

We request the following final-rule actions: retain ASP plus 6 percent for 340B drugs; conduct a new, independently validated acquisition-cost survey; explicitly recognize pharmacy-service costs; maintain the remedy offset at 0.5 percent; withdraw or narrow the site-neutral imaging proposal; phase and clinically validate inpatient-only list removals; defer expanded prior authorization until electronic workflows are ready; and simplify off-campus and transparency requirements.

If CMS nevertheless finalizes major changes, the agency should delay implementation for at least one year, cap any hospital's combined annual loss, establish exemptions for safety-net and essential community providers, publish hospital-specific impact files, and create an expedited hardship process. CMS should also monitor closures, service reductions, appointment availability, beneficiary travel, and disparities, with authority to suspend policies when access deteriorates.

Hospitals are not asking CMS to disregard affordability. We are asking the agency to recognize that sustainable access requires a financially and operationally capable delivery system. The final rule should lower costs without diverting 340B resources from vulnerable communities or placing multiple destabilizing policies into effect at once.

We appreciate your consideration and stand ready to work with CMS on alternatives that protect beneficiaries, taxpayers, and the hospitals that serve them.

Sincerely,

[NAME], President and Chief Executive Officer

[NAME], Chief Financial Officer

[NAME], M.D., Chief Medical Officer

[NAME], R.N., Chief Nursing Officer

[NAME], Pharm.D., Chief Pharmacy Officer

[NAME], M.D., President, Medical Staff

[HEALTH SYSTEM NAME]

[ADDRESS]