Center on Health Policy at BROOKINGS

August 31, 2026

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services (HHS)

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services (CMS)

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1850-P)

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to comment on the Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule. This letter makes two main points:[1]

1. CMS' proposal to apply site-neutral payment to imaging without contrast services furnished in excepted off-campus hospital outpatient departments (HOPDs) would reduce Medicare and beneficiary costs and weaken incentives for vertical consolidation without adversely impacting Medicare beneficiaries. Moreover, the economic logic underlying CMS' proposal supports further expanding site-neutral payment to additional services and, likely particularly important, on-campus settings. To identify additional services suitable for site-neutral payments, CMS could use a systematic empirical framework that considers whether services are routinely delivered in lower-cost settings, the magnitude of site-of-service payment differences, and evidence that those differences are contributing to shifts toward HOPDs. Finally, CMS could more fully achieve its goal of site-neutrality by more precisely aligning its "PFS-equivalent" rates with actual Physician Fee Schedule (PFS) payment rates.
2. Improving and standardizing payer and plan information in Hospital Price Transparency (HPT) data would make these data more useful. However, we are unaware of suitable standardized plan and payer identifiers, much less ones that are routinely available to hospitals, so hospitals may be unable to report such information, at least without incurring large administrative costs. As an incremental step, CMS could consider requiring hospitals to report a standardized market-segment or line-of-business field, which should be more feasible and still useful to data users. More generally, we note that there is substantial overlap between the HPT data and insurers' Transparency in Coverage (TiC) data, and as the TiC data improve, the policy rationale for robust HPT reporting will likely weaken.

The remainder of this letter examines these points in greater detail.

CMS' Imaging Proposal Would Advance Site-Neutral Payment, but CMS Could Go Further

CMS proposes to apply a PFS-equivalent rate to imaging without contrast services furnished in excepted off-campus provider-based departments; the proposal relies on its authority under section 1833(t)(2)(F) of the Social Security Act to control unnecessary increases in the volume of covered outpatient department

[1] The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than ourselves.

services. This section of our letter briefly analyzes the consequences of CMS' proposal and then considers how CMS could, if it wished, make further progress toward the goal of site-neutrality in Medicare.

CMS's imaging proposal would reduce costs and consolidation incentives while preserving access to care

CMS' proposed change would reduce what Medicare pays for the targeted services, which would both reduce federal spending and reduce beneficiary premiums and cost-sharing. These savings would likely be sizeable; CMS' estimates indicate that the proposal would reduce total payments by $260 million in 2027, including $190 million in Medicare savings and $70 million in reduced beneficiary coinsurance, and would reduce net Part B spending by $7.2 billion over 2027-2036.[2] At the same time, this change is unlikely to adversely affect Medicare beneficiaries' ability to access these services; they are routinely delivered in office settings today, which strongly suggests that PFS rates are sufficient to cover the cost of the patients treated in that setting, and analysis by the Medicare Payment Advisory Commission (MedPAC) concluded that the patients treated in the HOPD setting are not more complex in ways that make them costlier to treat. .[3]

Finalizing the proposal would also weaken hospitals' incentives to shift imaging services into excepted HOPDs, whether by relocating practices that a hospital already owns or acquiring new ones. As we discussed in comments on last year's OPPS proposed rule, research suggests that Medicare's site-of-service payment differentials have contributed to hospital-physician integration (although these payment rules are plainly only one of many factors driving consolidation).[4] Hospital acquisitions of physician practices likely tend to reduce competition in the market for physician services and, in turn, place upward pressure on the prices that commercial insurance plans pay for care.[5] More generally, shifting services into HOPDs may create hassle costs for patients if the HOPDs are less conveniently located than the physician offices they replace.

The economic logic of CMS' proposal applies to more services and settings

The proposed rule expressly solicits comments on other services or approaches for which CMS should exercise its authority under section 1833(t)(2)(F).[6] In that vein, we note that the core economic rationale for adopting site-neutral payment for ambulatory services applies directly both to other types of services and, more quantitatively important, to services delivered in on-campus HOPDs. We discuss each in turn:

- *Additional service lines:* One natural next step would be to apply similar changes to additional services. CMS has now addressed the three service categories where the largest dollars were at stake in the framework developed by the Medicare Payment Advisory Commission (MedPAC) for aligning OPPS and PFS payment rates. Based on 2019 data, clinic visits, imaging without contrast, and drug administration together accounted for about two-thirds of Medicare program spending on

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[2] Centers for Medicare & Medicaid Services (CMS), "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs," 91 Fed. Reg. 41734, 41908-41917 (July 7, 2026), https://www.federalregister.gov/d/2026-13656.

[3] Medicare Payment Advisory Commission (MedPAC), *Medicare and the Health Care Delivery System* (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

[4] Loren Adler and Matthew Fiedler, "Comments on Site-Neutral Payment Provisions of CMS' Proposed OPPS Rule," Brookings Institution (September 2025), https://www.brookings.edu/articles/comments-on-site-neutral-payment-provisions-of-cms-proposed-opps-rule/. See also David Dranove and Christopher Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy* 11, no. 4 (2019): 249-271, https://doi.org/10.1257/pol.20170020.

[5] Hannah T. Neprash, Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, and J. Michael McWilliams, "Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices," JAMA Internal Medicine 175, no. 12 (2015): 1932–1939, https://doi.org/10.1001/jamainternmed.2015.4610; Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," Journal of Health Economics 59 (2018): 139–152, https://doi.org/10.1016/j.jhealeco.2018.04.001; Thomas G. Koch and Shawn W. Ulrick, "Price Effects of a Merger: Evidence from a Physicians' Market," Economic Inquiry 59, no. 2 (2021): 790–802, https://doi.org/10.1111/ecin.12954.

[6] CMS, 91 Fed. Reg. 41734, 41917.

the services MedPAC identified as candidates ripe for payment alignment.[7] Nevertheless, substantial savings could still be realized by encompassing the remaining services as well.

CMS could likely make more rapid progress toward this goal if it adopted a systematic empirical approach to identifying services instead of proceeding one service family at a time. Such an approach would require two basic prongs. The first is a systematic method for identifying services that can be safely and economically delivered in the office setting. MedPAC's proposal of selecting services based on whether they are delivered in an office setting a plurality of the time is one potential approach.[8] However, in prior work with Benedic Ippolito, we noted that this approach may fail to identify some services that are suitable for site-neutral payment because current site-of-service payment differentials may have already caused service delivery to migrate out of office settings and into HOPDs.[9] One imperfect way of coping with this problem would be to include any services that are delivered in office settings some minimum fraction (e.g. 30 percent) of the time, rather than solely including services that are *most frequently* delivered in the office setting.

The second needed prong, which is necessary to allow CMS to use its authority under section 1833(t)(2)(F), is a method for identifying services where site-of-service payment differentials are causing services to shift into the HOPD setting. Here, CMS could use an approach similar to the one it has used to justify its prior proposals. Namely, it could look at trends in HOPD utilization or share for the services of interest as compared to trends in office or ASC settings. Additionally, CMS could examine the magnitude of the payment differential between the HOPD and office settings.

- *On-campus services:* While there are clear opportunities to expand site-neutral payment to additional service lines, CMS could also consider expanding site-neutral payment for its selected services to services delivered in on-campus HOPDs. Notably, the economic rationale CMS gives for its imaging proposal and its prior efforts to expand site-neutral payment does not turn on whether a HOPD is on- or off-campus. If a service can safely and economically be provided in a physician office or ASC, then paying substantially more when the same service is furnished in an on-campus HOPD raises Medicare spending and beneficiary cost-sharing without meaningfully improving access to care and creates incentives to acquire physician practices and shift services into HOPDs.

  Expanding site-neutral payment to on-campus settings would likely be more quantitatively important than expanding it to additional types of services in excepted off-campus HOPDs. While we are unaware of published estimates on how volume for the relevant services is split across on- and off-campus settings, recent cost estimates from the Congressional Budget Office (CBO) illustrate the difference in scale. CBO estimated that applying site-neutral rates to all imaging services and drug administration services delivered in off-campus HOPDs would reduce federal outlays by around $13

[7] Loren Adler, "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care," testimony before the U.S. House Committee on Energy and Commerce, Subcommittee on Health (April 26, 2023), Exhibit 3, https://www.brookings.edu/wp-content/uploads/2023/04/2023-04-26-EC-Competition-Transparency-Testimony-Final.pdf. The tabulation, based on MedPAC data for 2019, reports $3.029 billion in program spending for clinic visits, $2.587 billion for imaging without contrast, and $2.086 billion for drug administration, compared with $11.628 billion across all listed categories. See also Medicare Payment Advisory Commission (MedPAC), *Medicare and the Health Care Delivery System* (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC_v2.pdf.

[8] Medicare Payment Advisory Commission (MedPAC), *Medicare and the Health Care Delivery System* (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

[9] Loren Adler, Matthew Fiedler, and Benedic Ippolito, "Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce," Brookings Institution (May 12, 2023), https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/.

billion over a ten-year period;[10] the MedPAC data cited above suggest that this would have reached around half of the off-campus services potentially suitable for site-neutral payments that were not already subject to them and, thus, that applying site-neutral payment to a broad set of services in off-campus settings might generate savings on the order of $20-30 billion over ten years.[11] By comparison, CBO estimated that applying site-neutral rates to a comprehensive set of services in both on- and off-campus settings would reduce outlays by $157 billion over ten years.

We note that we do not take a position on the outer limits of CMS' authority under section 1833(t)(2)(F), as we lack the legal expertise to do so. In some cases, the limits on this authority may constrain CMS' ability to expand site-neutral payments to additional services or settings. But we emphasize that the core economic rationale for site-neutral payment applies much more broadly than it has been applied to date.

Achieving full site neutrality requires more precise alignment with PFS payment rates

We also highlight a narrower implementation issue that we raised in our comments on last year's proposed rule. CMS has implemented its site-neutral policies by paying 40 percent of the otherwise applicable OPPS amount and describes that amount as "PFS-equivalent." But a fixed percentage of the OPPS rate will not generally equal the amount Medicare would pay for the same services under the PFS.

This year's proposed rule again illustrates the issue. CMS reports that PFS payments for the imaging without contrast ambulatory payment classifications (APCs) range from about 31 percent to 54 percent of OPPS payments. A uniform 40 percent multiplier therefore leaves some services above the PFS amount and others below. If the policy goal is to eliminate distortions created by differences between PFS and OPPS rates, the natural benchmark is the payment that would actually occur under the PFS. To get closer to this ideal, CMS could base site-neutral rates more directly on the PFS rate for the technical component of a service, with code-specific adjustments where OPPS packaging rules make a direct comparison inappropriate.[12]

Adding Better Payer and Plan Identifiers to HPT Data Would Be Useful, but Potentially Infeasible

The proposed rule also requests comment on ways to improve the standardization and comparability of HPT data, including whether hospitals should report more structured information about payers, plans, products, networks, and employers and whether existing payer or plan identifiers available to hospitals could be incorporated into the machine-readable files.[13] We agree that expanding and standardizing payer and plan information could materially improve the usefulness of these data by making it easier to identify which coverage arrangement a reported price corresponds to and to compare those prices across hospitals.

Unfortunately, we are unaware of suitable standardized payer or plan identifiers. All of the standardized identifiers that we are aware of are specific to particular market segments and thus would miss many plans (and payers) included in the HPT data. Moreover, even the identifiers that do exist are likely not routinely available to hospitals. Thus, we do not see a feasible near-term path to requiring hospitals to report this type of information, certainly not without placing sizeable new administrative burdens on hospitals.

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[10] Congressional Budget Office (CBO), "Reduce Payments for Hospital Outpatient Departments" (December 12, 2024), https://www.cbo.gov/budget-options/60908.

[11] Medicare Payment Advisory Commission (MedPAC), *Medicare and the Health Care Delivery System* (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC_v2.pdf.

[12] CMS, 91 Fed. Reg. 41734, 41913. CMS reports that, at the APC level, PFS payments for imaging without contrast range from about 31 percent to 54 percent of OPPS payments.

[13] CMS, 91 Fed. Reg. 41734, 41997-41998. CMS specifically asks whether it should require more structured reporting of payer, plan, product, network, and employer information and whether there are existing payer or plan identifiers available to hospitals that should be incorporated into the HPT machine-readable files.

A more achievable—but still valuable— step would be to require a standardized market-segment or line-of-business field indicating, for example, whether a particular plan is group coverage, nongroup coverage, Medicare Advantage, or Medicaid managed care. This would not fully identify the plan or payer in question, but it would still address a major limitation of the current files; such a field could likely be populated using information that hospitals already have available. CMS could also explore creating standardized plan or payer identifiers that cut across market segments and thus could be used in future years.

More broadly, in weighing the costs and benefits of new and existing HPT reporting requirements, it is important to recognize that the information that hospitals report under the HPT rules overlaps substantially with what health plans and issuers report under the TiC rules. In practice, many types of information may be less costly to obtain through TiC or through linkages between payer- and hospital-reported data than from hospitals via the HPT data. Indeed, if CMS succeeds in its efforts to improve the TiC data and ultimately expands similar requirements to plans in other market segments (e.g., Medicare Advantage or Medicaid managed care), then the policy rationale for continuing HPT reporting may largely disappear.

Thank you for the opportunity to comment on this proposed rule. We hope that this information is helpful to you. If we can provide additional information, we would be happy to do so.

Sincerely,

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