August 31, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Calendar Year 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Proposed Rule

CMS-1850-P

Dear Dr. Oz,

Thank you for the opportunity to respond to the proposed CY 2027 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems rule. Arnold Ventures strongly supports the Administration's commitment to expanding site-neutral payment reform and strengthening hospital price transparency to lower health care costs, improve patient choice, and enhance health care market competition. We look forward to the Administration's continued efforts on these issues, which have implications for both Medicare and the commercial market.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. As a philanthropy, we do not accept funding from industry or have a financial stake in policy outcomes. Our work within the health care sector is driven by a recognition that the current system costs too much, leading to access issues for patients and affordability challenges for families and businesses. Given that health care consolidation is a primary driver of high and rising provider prices in the commercial market, part of our work to lower health care costs for families, employers, and taxpayers is aimed at improving market competition and preventing further consolidation. Additionally, we are focused on policies that improve transparency and directly limit commercial prices or price growth where appropriate.

As you will see below, we strongly urge the Administration to finalize its proposal to implement site-neutral payments for imaging services without contrast. We also outline recommendations for expanding site-neutral payments beyond those proposed in this rule and undertaken in previous years in order to lower costs for Medicare beneficiaries and the Medicare program, and to reduce incentives for hospitals to vertically consolidate with providers. We are also

encouraged to see that the Administration continues to solicit feedback on improvements to the hospital price transparency requirements in order to ensure that consumers, employers, researchers, and policymakers have the necessary data to pursue lower-cost care and inform policy development aimed at improving health care affordability. We thank the agency for its work in this area, given your many competing priorities, and appreciate the opportunity to provide input.

General Principles for Site-Neutral Payment Reform

Patients and taxpayers are charged billions more simply because of where they receive care. Medicare generally pays two to four times more for a given service provided in a hospital outpatient department (HOPD) than they do when that same service is delivered in a physician's office – even when the service can be safely and routinely delivered regardless of care setting.[1] This has encouraged hospitals to buy up physician practices and rebrand them as HOPDs to bill for the same services at the higher hospital rate – even when the doctor and services remain the same.

These payment differentials for different sites of service drive consolidation and lead services to move to more expensive sites of care. They also exist in the commercial market, raising costs and prices for those with commercial insurance and increasing taxpayer subsidies for commercial insurance. As hospital systems grow larger, they are then able to leverage their market power to demand higher commercial prices in insurer negotiations for all of their services, given reduced competition. There is substantial evidence that this does not improve the quality of care despite the increase in patients' premiums and cost sharing.[2]

Medicare's adoption of site-neutral payment policy would reduce payment differentials for routine and safe services to ensure patients and taxpayers pay the same amount for the same services regardless of where the service is performed. **Arnold Ventures supports legislative action to enact comprehensive site-neutral reform in both Medicare and the commercial market.[3] Such legislation would:**

- Lower Medicare spending and save around $150 billion for taxpayers over 10 years.[4]
- Reduce Medicare beneficiaries' premiums and cost sharing by $80 billion over 10 years.[5]

[1] Actuarial Research Corporation. 2024. *Without Site Neutrality, the Differential in HOPD and Office Medicare Payments is Growing Faster than Medical Inflation.* https://assets.arnoldventures.org/uploads/Site-Neutrality-Growing-Differential-2024.11.14.pdf.
[2] KFF. 2024. *Ten Things to Know About Consolidation in Health Care Provider Markets.* https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/
[3] Arnold Ventures. 2025. *New Research Brief Finds Billions in Savings for Seniors.* https://www.arnoldventures.org/stories/new-research-brief-finds-billions-in-savings-for-seniors
[4] Ibid.
[5] Ibid.

- Save employers and consumers in the commercial market between $140 billion and $470 billion.[6]

CMS Proposal on Site Neutrality for Imaging Services Without Contrast

Arnold Ventures strongly supports the Administration's proposal to pay for imaging services without contrast on a site-neutral basis when performed at off-campus hospital outpatient departments. We share CMS's concern that payment disparities between settings are driving beneficiaries into higher-cost settings for routine imaging services that could be safely provided in a lower-cost setting – increasing costs for beneficiaries, driving up spending in the Medicare program, and further incentivizing hospital consolidation.

CMS's approach to paying at a rate consistent with the level at independent physician offices makes sense given the fact that imaging services without contrast are performed frequently and safely at these offices. This is also a reasonable use of CMS's authority to control the increased volume of these services at higher cost sites-of-care, consistent with the methodology used in 2026 for drug administration services and in 2019 for evaluation and management services (E&M) for off-campus HOPDs previously "excepted" from the Bipartisan Budget Act (BBA) of 2015's site-neutral payment rates, which only applied to locations built after the legislation's passage.

As CMS reports in this proposed rule, payment rates for imaging services without contrast at excepted sites-of-service are about 2.5 times higher than the rates at non-excepted locations, with average cost sharing for beneficiaries also being more than double – a payment differential that has driven unnecessary growth in service volume at higher-cost settings rather than physician offices. This growth in volume ultimately translates to wasteful government spending and higher costs for patients. Beyond Medicare, these trends are also exhibited in the commercial market. An analysis of 2022 data from the employer-sponsored insurance market by the Health Care Cost Institute found that commercial prices at HOPDs for imaging services without contrast ranged from two to four times higher than prices at physician offices.[7]

Correcting these payment differentials would help address shifts in service volume to high-cost settings and reduce costs for beneficiaries and taxpayers. The Actuarial Research Corporation (ARC) recently estimated that implementing site-neutral payments for imaging services without contrast in off-campus HOPDs would result in $5.8 billion in federal savings and $3.1 billion in

[6] Committee for a Responsible Federal Budget. 2021. *Equalizing Medicare Payments Regardless of Site-of-Care.* https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.
[7] Health Care Cost Institute. 2026. *Imaging Services are the Second Most Common Outpatient Service.* https://healthcostinstitute.org/wp-content/uploads/2026/03/Imaging-Brief_Final.pdf.

beneficiary savings over 10 years, similar to CMS's projected reductions of $7.2 billion in Part B spending and $2.5 billion in beneficiary cost sharing.[8]

Opportunities for CMS Action to Expand Site-Neutral Reforms to Additional Services

In the CY 2026 OPPS rule, CMS requested comment on moving to site-neutral payments for E&M services at on-campus HOPDs, following their previous implementation of site-neutral payments for E&M services at all off-campus locations in 2019. While CMS did not address this issue in the CY 2027 proposed rule, we strongly encourage CMS to implement site-neutral reforms for on-campus E&M visits in future rulemaking, as these services are primarily and routinely provided in physician offices. **Arnold Ventures supports paying for all E&M visits, whether at on- or off-campus outpatient departments, at the lower independent physician rate. This would save taxpayers an estimated $24 billion and reduce beneficiary premiums and cost sharing by around $13 billion over 10 years**.[9]

In addition, CMS requested suggestions for other services that they should consider for an expansion of site-neutral payments under their volume control authority. We strongly encourage CMS to continue to take action to expand site-neutral payments in future rulemaking and recommend the MedPAC list of 66 clinical services as a starting point.[10, 11] It includes 57 Ambulatory Payment Classifications (APCs) where services are most commonly provided in freestanding physician offices – making those natural choices for which to align payments at the lower rates paid to physician offices. Furthermore, these services account for a substantial majority of Medicare service volume under OPPS, though a lower share of spending.[12]

Expanding site-neutral payments to the remaining APCs in the MedPAC list would save Medicare $9.3 billion over 10 years and beneficiaries $5 billion in reduced premiums and cost sharing.[13] These savings would be in addition to those generated by the finalized 2026 policy on drug administration services and the 2027 proposal for imaging services without contrast.

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[8] Arnold Ventures. 2026. *Site Neutrality: Impact of Payment Differentials and Updated Savings Estimates.* *https://assets.arnoldventures.org/uploads/PDFs/Site-Neutrality-Impact-of-Payment-Differentials-and-Updated-Savings-Estimates.pdf*.

[9] Arnold Ventures. 2026. *Site Neutrality: Impact of Payment Differentials and Updated Savings Estimates.* *https://assets.arnoldventures.org/uploads/PDFs/Site-Neutrality-Impact-of-Payment-Differentials-and-Updated-Savings-Estimates.pdf*.

[10] Medicare Payment Advisory Commission. 2022. *Report to Congress. Chapter 6: Aligning fee-for-service payment rates across ambulatory settings.* https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[11] Medicare Payment Advisory Commission. 2023. *Report to Congress. Chapter 8: Aligning fee-for-service payment rates across ambulatory settings.* https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

[12] Ibid.

[13] Arnold Ventures. 2026. *Site Neutrality: Impact of Payment Differentials and Updated Savings Estimates.* *https://assets.arnoldventures.org/uploads/PDFs/Site-Neutrality-Impact-of-Payment-Differentials-and-Updated-Savings-Estimates.pdf*.

Volume Methodology Considerations for Site-Neutral Reforms

To date, CMS has focused on services where data has shown absolute increases in the share of services in HOPDs over time. However, a recent analysis by ARC, which uses Maryland as a counterfactual given its global budget model for hospitals, suggests that Medicare payment differentials may be increasing relative HOPD utilization even for services where the absolute trend has appeared to remain flat.[14] ARC found that for a number of services, HOPD utilization increased or remained flat in the rest of the country yet was lower and continued to decline in Maryland. For example, between 2017 and 2024, the share of E&M visits delivered in HOPDs in the rest of the country rose from 13 percent to 14 percent, while the share in Maryland declined from 8 percent to 6 percent.

The ARC analysis also provides further support for CMS's current proposal on imaging services without contrast. In addition to the evidence CMS provides of volume growth in imaging at hospital-owned locations, ARC's research shows that between Maryland and the rest of the country, imaging services without contrast have dramatically diverged in volume by site of care, with the share in Maryland delivered at HOPDs dropping from 32 percent to 24 percent from 2017 to 2024.[15] As a result, by 2024, the share of imaging services without contrast delivered in HOPDs in Maryland was 26 percentage points lower than the rest of the country. These findings suggest that outside of Maryland, payment differentials may be counteracting a secular trend of clinical advances allowing more services to be delivered safely and at lower cost in physician offices and ambulatory surgical centers.

In addition to the 66 APCs in the MedPAC list, the ARC analysis highlights 16 additional APCs that represent strong candidates for site-neutral payment (e.g., levels 1 and 2 imaging with contrast). **Expanding site neutrality for these 16 additional APCs would save Medicare $4.3 billion over 10 years and beneficiaries $2.3 billion in reduced premiums and cost sharing.**[16]

Beyond exercising its volume control authority over additional services, there are other incremental steps CMS can take to expand site-neutral reforms, including by narrowing the definition of free-standing emergency departments to those that function truly as an emergency department, such as those that provide most services on an unscheduled basis.

Request for Information on Strengthening Hospital Price Transparency Requirements

The primary driver of high health care costs for the privately insured is the excessive prices for health care services charged by powerful hospitals and providers. These prices – on average, 2.5 times more than what Medicare pays for the same service – are often set arbitrarily and are

[14] Ibid.
[15] Ibid.
[16] Ibid.

irrationally high.[17] These high prices flow through the system as a tax on consumers and employers in the form of rising premiums and out-of-pocket costs, including high deductibles.[18] Given these high costs, nearly half of Americans in 2026 reported difficulties affording their health care costs.[19]

Arnold Ventures supports the Administration's efforts to advance greater price transparency and appreciates its continued efforts in this rule to improve the standardization and comparability of Hospital Price Transparency (HPT) data. Unlike in most other markets, patients, employers, and other health care purchasers are often forced to make care decisions without clear pricing information. Fundamentally, consumers should have access to such information before they seek health care services. Furthermore, reliable price data is essential to revealing the high and rising prices charged by hospitals and the widespread variation in prices for the same services within markets and hospitals – as well as the role of consolidation and provider market power in driving this variation. While the evidence suggests that price transparency alone is likely not sufficient to reduce prices, such data can inform purchaser efforts to negotiate lower prices and enables researchers and policymakers to develop policy solutions to improve health care affordability.[20]

Beyond the questions on data standardization considered in this RFI, we also encourage the Administration to continue to explore ways to improve compliance with the HPT rules. While the HPT rules have been an important step forward in making hospital price transparency data available for patients, employers, and researchers, we continue to have concerns about hospital compliance with the requirements based on previous evaluations.[21] **We applaud the Administration's recent enforcement efforts, including sending warning letters to more than 500 non-compliant hospitals. We encourage the Administration to keep exercising this enforcement authority and to consider additional changes to strengthen enforcement.**

Concurrent with administrative enforcement efforts, we also support legislative action to codify the Hospital Price Transparency rules – as well as the insurer Transparency in Coverage rules – and to strengthen enforcement, including by increasing the daily noncompliance penalties and raising the maximum penalties for persistent noncompliance.

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[17] Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, Brian Briscombe, Rose Kerber, Brenna O'Neill, Aaron Kofner. 2024. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative.* https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

[18] KFF. 2025. *Employer Health Benefits: Annual Survey 2025.* https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.

[19] KFF. 2026. *Americans' Challenges With Health Care Costs.* https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/

[20] Glied, Sherry. JAMA Forum. 2021. *Price Transparency—Promise and Peril.* https://jamanetwork.com/journals/jama/fullarticle/2778818?resultClick=1.

[21] Department of Health and Human Services, Office of the Inspector General. 2024. *Not All Selected Hospitals Complied With the Hospital Price Transparency Rule*. https://oig.hhs.gov/reports/all/2024/not-all-selected-hospitals-complied-with-the-hospital-price-transparency-rule/.

Codification of Unique National Provider Identifier Requirements

We appreciate CMS taking action in this rule to codify the provision of the Consolidated Appropriations Act, 2026 to require off-campus HOPDs to bill Medicare using a separate National Provider Identifier (NPI). We have long been supportive of proposals to enhance site-of-service billing transparency in Medicare, and continue to support extending this transparency to the commercial market. By requiring hospitals to disclose where care is provided, this policy represents an important first step to protect patients from inappropriate facility fees and lower costs for individuals and businesses. As CMS implements this requirement, we encourage the agency to maintain a regular provider-based attestation process. Given the rapid pace of provider consolidation, acquisitions, and organizational restructuring across the health care sector, we believe the initial 2-year lookback period is appropriate and recommend that subsequent attestations be required at least every three years as opposed to the proposed five-year period. More frequent attestations will help ensure that provider-based status information remains current and reliable, enhancing the integrity and usefulness of the NPI system over time.

We look forward to continuing to work with you on these important issues and are available for further discussions on the above. Please contact Alexandra Spratt, Vice President, Health Care (ASpratt@arnoldventures.org) and Mark Miller, Executive Vice President, Health Care (Mmiller@arnoldventures.org) with any questions.

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