AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

**Re: File Code CMS–1850–P.** Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2027 Notice of Proposed Rulemaking (Proposed Rule) on the revisions to Medicare Payment Policies under the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System, published in the Federal Register on July 7, 2026.

Provided below are the AMA's key recommendations:

*ASC Payments.* The AMA supports CMS' continued use of the hospital market basket to update ASC payments, which reduces longstanding disparities and supports migration of appropriate cases to lower-cost settings. We again urge CMS to discontinue the ASC scalar, which suppresses ASC rates without statutory requirement and discourages that migration, or in the alternative to combine OPPS and ASC utilization into a single budget neutrality calculation. We further recommend that CMS extend OPPS geographic reclassification and wage index floor policies to ASCs so that facilities competing in the same labor markets are treated consistently.

*Site Neutrality for Imaging Without Contrast.* The AMA supports site neutral payment in principle but not at the expense of overall Medicare funding and continues to urge CMS to reinvest the estimated $260 million in projected first-year savings into other Part B services, including the Medicare Physician Fee Schedule (MPFS), rather than removing those dollars from the program. Beyond that concern, the evidence CMS offers does not support applying a payment rate across the full range of imaging services this proposal would reach, and CMS has not yet evaluated the similar expansion it finalized last year for drug administration services. The AMA urges CMS to evaluate its prior policy before expanding further

and to target any reduction to the services its own data show are affected. The AMA supports the proposed exemption for rural Sole Community Hospitals (SCHs).

*Inpatient Only (IPO) List.* The AMA supports removing services from the IPO list where evidence demonstrates they can be furnished safely in the outpatient setting for the Medicare population, but urges CMS to ground each phase of the elimination in the kind of clinical and utilization evidence that has historically supported IPO list removals, at least at the level of clinical families where code-by-code review is no longer practical, and to let clinical and payment system readiness, rather than a fixed calendar, determine the pace. The AMA further urges CMS to preserve and strengthen the medical review protections that safeguard physicians' clinical judgment once services leave the list, and to confirm that Medicare Advantage plans will not deny medically necessary inpatient admissions based solely on site of service.

*340B Payment Methodology.* The AMA supports CMS' survey-based approach to pay average sales price (ASP) minus 33.4 percent for 340B-acquired drugs, including in nonexcepted off-campus Provider-Based Departments (PBDs), which narrows a payment advantage that depends on hospital ownership, reduces incentives to acquire independent physician practices, and lowers beneficiary cost sharing.

*Payment for Skin Substitutes.* The AMA supports maintaining the CY 2026 skin substitute payment framework unchanged for CY 2027 while a full year of claims data is collected and urges CMS to closely monitor beneficiary access and payment alignment across care settings.

*Software as a Medical Service (SaMS).* The AMA supports the terminology change from "Software as a Service" (SaaS) to SaMS and CMS' interim approach of assigning designated SaMS technologies to New Technology Ambulatory Payment Classifications (APCs), provided SaMS functions as an interim payment designation rather than a competing coding taxonomy. The AMA does not support removing 10 HCPCS codes describing SaMS analyses performed on laboratory tests from the Clinical Laboratory Fee Schedule (CLFS) and urges CMS to withdraw that list pending a code-by-code technical review with the relevant stakeholders.

*Prior Authorization for Botulinum Toxin.* The AMA does not believe that the utilization data in the proposed rule establish inappropriate use and urges CMS to examine growth by service and indication before finalizing. If CMS proceeds, it should allow a single authorization to cover a full course of therapy (at least 12 months) and require decisions within 72 hours for standard and 24 hours for expedited requests, consistent with the standards CMS applies to Medicare Advantage.

*Provider-based Status (Section 6225).* The AMA supports the identification and transparency objectives of section 6225 and its implementation through a standardized, centralized attestation process. We urge CMS to implement these requirements in a way that maximizes accuracy and minimizes administrative burden, particularly for small, rural, and independent facilities, and the independent physicians whose patients depend on continued access to provider-based services. The AMA also urges CMS to publish the standardized attestation form for public comment before finalizing it.

*Hospital Price Transparency.* The AMA recommends that CMS pursue standardization that makes hospital prices genuinely comparable across the settings in which a service may be furnished without extending a price-posting mandate to physician practices.

*Quality Reporting.* The AMA supports removing the *Follow-up from Normal Colonoscopy* measure, which was not designed to assess facility performance. The AMA also reiterates its concern that the Emergency Care Access and Timeliness electronic clinical quality measure (eCQM) is moving to

mandatory reporting before its data elements can be reliably mapped and validated. Regarding the accompanying request for information (RFI), the AMA supports advanced care planning in concept, but urges further specification and testing before adoption. The AMA also supports stratifying the all-cause transfer/admission measure by phase of care.

## A. Updates Affecting ASC Payments

*Conversion Factor*

**Recommendation:**

- The AMA supports CMS' continued use of the hospital market basket as the annual update mechanism for ASC payments.

The AMA supports CMS' continued use of the hospital market basket as the annual update mechanism for ASC payments. The decision to align ASC and OPPS update factors was an important step forward in reducing the longstanding payment disparities that historically disadvantaged the ASC setting. When CMS aligned the ASC payment system with the OPPS in 2008, the goal was to encourage high-quality, efficient care in the most clinically appropriate outpatient setting and to eliminate payment incentives that favored one site-of-service over another. However, for many years CMS relied on siloed payment policies that exacerbated reimbursement gaps. Linking ASC updates to the Consumer Price Index for All Urban Consumers (CPI-U), which bore little relation to healthcare costs, left ASCs unable to keep pace with rising expenses and widened the disparity with hospitals.

The pilot launched in 2019 to use the hospital market basket for ASC updates marked an important recognition of this problem. We appreciate that CMS has continued this approach in the CY 2027 proposed rule, where the Agency proposes a 2.4 percent increase in ASC payments, based on a 3.2 percent hospital market basket update reduced by a 0.8 percent productivity adjustment. This translates into an estimated $9.9 billion in ASC payments for 2027, approximately $520 million more than in 2026. By continuing to tie ASC updates to the hospital market basket, CMS is helping to align payments across outpatient sites-of-service, reduce distortions, and strengthen access to care in lower-cost settings.

There are also signs that this alignment is supporting modest migration of services from the hospital outpatient department to the ASC. Between 2021 and 2023, ASC fee-for-service market share increased by 0.3 percent, while HOPD volume declined by a corresponding 0.3 percent. These changes, though small, demonstrate that payment policy can help drive clinically appropriate migration to the ASC setting when reimbursement policies support it.

The AMA emphasizes that maintaining this approach is critical to sustaining progress toward greater alignment between OPPS and ASC payments. At the same time, further reforms are needed to realize the full potential of the ASC setting. CMS' continued use of the ASC scalar, as well as restrictions on the ASC covered procedures list that CMS proposes to alleviate, limit the ability of surgery centers to absorb additional Medicare cases and discourage broader migration. Eliminating the ASC scalar and expanding the ASC covered procedures list as proposed would build on the positive effects of the market basket policy and provide beneficiaries with greater access to high-quality, lower-cost surgical care.

*Updating the ASC Relative Payment Weights for CY 2027*

**Recommendation:**

- The AMA urges CMS to discontinue its practice of rescaling the ASC relative weights to achieve a perceived budget neutrality objective.

While the alignment of update factors between the ASC and OPPS systems was a positive first step, the lack of alignment on other payment policies has left ASC reimbursement rates lagging far behind hospital outpatient department rates. On average, ASCs are reimbursed less than 50 percent of what hospitals receive for the same procedures. This disparity means that in too many markets, surgeries that could safely be performed in ASCs remain concentrated in hospitals, a dynamic that stems directly from Medicare's refusal to pay competitive rates to ASCs. The continued application of the ASC scalar threatens outpatient access to care and prevents ASCs from taking on the volume of Medicare cases they are clinically able to absorb. This lack of migration comes at a high cost to the Medicare program and to taxpayers.

Since aligning the payment systems, CMS has consistently taken OPPS relative weights, which are already scaled, and then applied a second adjustment through the ASC scalar before arriving at ASC payment weights. This outdated approach to cost containment, which tries to maintain budget neutrality in silos for each payment system, penalizes migration to a lower-cost site-of-service. The result is that any increase in ASC volume translates into stagnant or declining reimbursement rates within the ASC silo. There is no evidence of growing differences in capital or operating costs between ASCs and hospitals that would justify this widening payment gap. By applying the ASC scalar, CMS undermines the benefits of conversion factor alignment and limits the long-term savings that ASCs could deliver to the Medicare program.

Nothing in statute requires CMS to continue this practice. The 2008 law that established the current ASC payment system only mandated application of a budget neutrality adjustment in the first year. CMS' decision to perpetuate the scalar after that initial year was made under the Agency's own discretion, not congressional direction. The Agency therefore has full authority to discontinue the scalar today on the same rationale it used to extend it.

The AMA recognizes that eliminating the scalar would result in an initial increase in Medicare program spending. However, delaying action only compounds these costs, as ASC rates are further suppressed each year and more cases remain trapped in higher-cost hospital settings. The fiscal impact is expected to be substantially offset over time as procedure volume migrates into the ASC setting where care is delivered more efficiently. As an alternative, CMS could combine OPPS and ASC utilization into a single budget neutrality calculation. This would more accurately account for outpatient surgical volume across both sites-of-service and further the alignment of the two systems. Whether through full elimination or integration into a unified calculation, the current use of the ASC scalar is unsustainable and counterproductive.

*Wage Index Considerations*

**Recommendation:**

- The AMA recommends that CMS apply OPPS geographic reclassifications and wage index floor policies to ASCs to further harmonize payment systems.

The AMA supports policies that mitigate the impact of inadequate wage indices on rural ASCs. The current lack of alignment between the ASC and HOPD reimbursement methodologies is particularly

evident in wage indices. Hospitals are permitted to seek geographic reclassification when their location near a county line allows them to raise their wage index, but ASCs are barred from pursuing such reclassifications. This creates inequitable outcomes between facilities that serve the same patient populations and draw from the same labor markets.

The discrepancy is even more pronounced in frontier states, where hospitals are guaranteed a wage index floor of 1.0 while ASCs in the same areas are not afforded that protection. A frontier state is defined as one in which at least 50 percent of counties have a population density of fewer than six people per square mile, excluding Alaska and Hawaii. South Dakota meets this definition, and while hospitals in the state receive the floor adjustment, ASCs face a much lower rural wage index of 0.7979. This gap has serious implications for ASCs' ability to recruit and retain staff, particularly given ongoing workforce shortages that affect rural and frontier areas most acutely.

By again proposing to maintain geographic reclassification, the rural floor, and the frontier state floor for hospitals while continuing to pay ASCs off the pre-reclassified wage index with none of these protections, the CY 2027 proposed rule perpetuates a disparity in how the two systems treat identical labor markets. Hospitals benefit from multiple mechanisms intended to cushion them from the distortions of a wage index system that does not always reflect local labor costs, and CMS proposes to extend that logic further in CY 2027 by applying a cost-of-living adjustment to the non-labor share of OPPS payments in Alaska and Hawaii; a geographic cost protection likewise unavailable to ASCs. By contrast, ASCs remain excluded from these protections despite competing in the same markets for nurses, anesthesiologists, and other staff, and despite facing the same rising costs for labor, equipment, and supplies.

The AMA believes that applying these wage index policies to ASCs would advance CMS' goal of aligning outpatient payment systems and ensuring that beneficiaries in rural and frontier areas retain access to safe, high-quality surgical care. Allowing ASCs to benefit from reclassification opportunities and wage index floors would mitigate current inequities, provide financial stability to rural surgery centers, and better reflect the real costs of delivering care in geographically challenging areas. We therefore support CMS applying the same geographic reclassification and wage index floor policies to ASCs that are already available to hospitals under the OPPS.

### B. Method To Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

**Recommendations**

- The AMA supports Medicare payment policies for outpatient services that are site neutral without lowering total Medicare payments and urges CMS to reinvest the estimated $260 million in projected first-year savings into other Part B services, including the MPFS, while recognizing that durably addressing site-of-service volume growth also requires attention to MPFS payment adequacy in future rulemaking.
- CMS should evaluate the site neutral expansion it finalized in 2026 before extending this authority to a new category of services.
- Any payment reduction should be evidence-based and targeted to the services CMS' own data show are affected, rather than applied uniformly across the full range of imaging services this proposal would reach.
- The AMA supports the proposed exemption for rural SCHs.

CMS proposes to expand the MPFS-equivalent site neutral rate of 40 percent of the OPPS rate to imaging without contrast services furnished in excepted, off-campus HOPDs. The Agency would implement this change in a non-budget neutral manner, estimating savings of $260 million, with $190 million accruing to Medicare and $70 million to Medicare beneficiaries. CMS proposes to exempt off-campus PBDs of rural SCHs from this change.

Under the Bipartisan Budget Act of 2015, off-campus HOPDs that began billing Medicare under the OPPS after November 2, 2015, are paid at the site neutral rate. Other HOPDs were "grandfathered" and excepted from this policy. In 2019, however, CMS expanded the site neutral rate to include clinic visits in excepted, off-campus HOPDs. This change was implemented without budget neutrality and was upheld by the U.S. Court of Appeals for the District of Columbia Circuit as being within CMS' statutory authority. CMS has reported success in curbing unnecessary growth in off-campus clinic visits under this policy, but it continues to express concern about vertical consolidation. In 2026, CMS expanded the site neutral rate to include drug administration services furnished in excepted, off-campus HOPDs, citing data showing that hospital or health system ownership of cancer care practices doubled from approximately 30 percent to 60 percent between 2003 and 2015. CMS requested comments on other services that could be paid at the MPFS-equivalent rate in excepted, off-campus HOPDs, such as imaging without contrast. For CY 2027, CMS has proposed full OPPS payment rates for imaging without contrast APCs 5521 through 5524 (Levels 1–4 Imaging Without Contrast), as well as for APCs 8004, 8005, and 8007 (the multiple-imaging composite APCs for ultrasound and for CT/CTA and MRI/MRA without contrast). The proposed site neutral payments would be determined by applying the 40 percent relativity adjuster to these full OPPS rates.

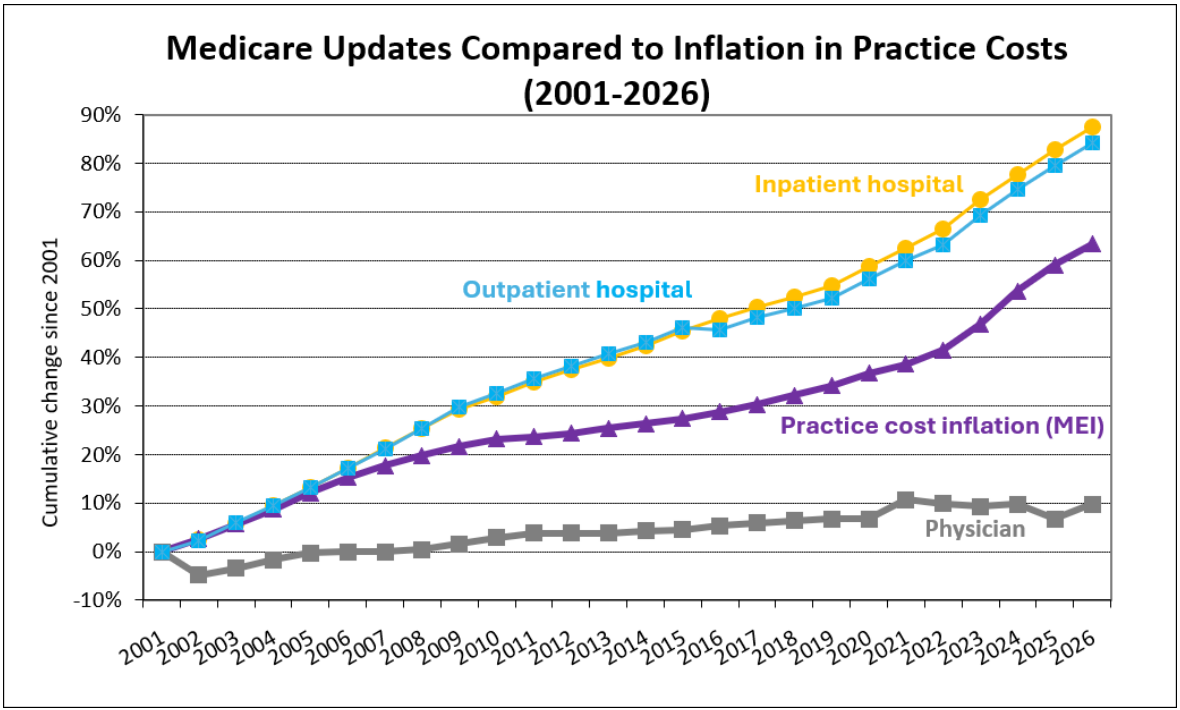
| APC | On-Campus HOPD Rate (Full OPPS Payment) | Off-Campus HOPD Payment Rate (OPPS Payment x 40% Relativity Adjuster) |
|---|---|---|
| 5521 | $97.91 | $39.16 |
| 5522 | $118.46 | $47.38 |
| 5523 | $271.13 | $108.45 |
| 5524 | $622.55 | $249.02 |
| 8004 | $326.30 | $130.52 |
| 8005 | $247.29 | $98.92 |
| 8007 | $591.20 | $236.48 |

*Site Neutrality Should Not Reduce Overall Medicare Funding*

The AMA agrees with CMS that competition in healthcare is critical to ensure patients have choices for where to receive care. However, we do not believe competition should become a race to the bottom. Consistent with the AMA's comments on the CY 2026 proposal extending this same authority to drug administration services, the AMA supports site neutral payment policies in principle but does not believe site neutrality should be achieved by removing net dollars from the Medicare program. The AMA raised these same funding concerns last year, and CMS nonetheless finalized the drug administration policy for CY 2026. We reiterate that concern here, but our principal objection to the CY 2027 proposal is narrower and more specific: as explained below, the evidentiary basis for extending this authority to imaging without contrast is materially weaker than the record CMS assembled for its prior expansions. Achieving site neutral payments for outpatient services and procedures will require increases in Medicare physician payment so that practices can remain financially viable and patient choice of care setting is safeguarded. Reducing payments to the lowest amount paid in any setting does not support physicians. The disparity between OPPS and MPFS payment rates reflects, in part, inadequate rates paid to physician offices and

should not be interpreted solely as OPPS overpayments. A significant disconnect exists between what Medicare pays and what it costs to operate a modern physician practice. As a result, the AMA urges CMS to replace this policy proposal with one that raises MPFS rates.

The payment gap between physician practices and HOPDs stems in large part from the absence of an annual inflation-based update to Medicare physician payment. Nearly all other Medicare providers, including hospitals, receive automatic annual inflation-based updates. Between 2001 and 2025, Medicare physician pay increased only 7 percent, or 0.3 percent per year on average, even though the cost of operating a medical practice increased 59 percent, or 2.0 percent per year on average. Adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025, or 1.7 percent per year on average. In comparison, Medicare hospital updates totaled approximately 80 percent, or 2.5 percent per year on average, with inpatient services increasing by 83 percent and outpatient services by 80 percent.




Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Rather than implementing this proposal as a net reduction that removes an estimated $260 million in year one alone from Medicare spending for outpatient care, CMS should treat the adequacy of Part B payment, including the MPFS, as the necessary counterpart to any site neutral policy. The AMA recognizes that the OPPS and MPFS are separate payment systems and that CMS cannot mechanically transfer an outlay reduction in one into higher payments in the other. That structural separation is precisely why the AMA urges CMS not to treat this proposal as a standalone spending cut; as services and procedures shift from the hospital outpatient setting to ambulatory settings, physician payment, particularly the practice expense that sustains office-based care, must keep pace, rather than allowing OPPS site neutral savings to leave the Part B system entirely. The AMA urges CMS to use every tool at its disposal, and to work with Congress where its own authority is limited, to ensure this occurs.

The AMA fully supports CMS' goal of encouraging care in lower cost settings, which in turn reduces patient cost sharing. To achieve this aim, CMS must ensure that patients have access to user friendly and real time information about the cost differences between outpatient care settings. Many patients are

currently unaware of the additional costs they face when receiving services at hospital outpatient designated clinics, particularly facility fees that can significantly increase financial responsibility. At the same time, they may not fully understand the associated benefits that hospitals can provide, such as higher levels of treatment capability if needed for a given condition.

To empower patients to choose lower cost settings of care when clinically appropriate, the AMA urges CMS to require proactive transparency about these added costs. Information on the cost differences between hospital outpatient departments, ambulatory surgery centers, and physician offices should be made clear to patients. The Agency should also require that the additional costs of facility fees compared to professional services be disclosed at the time of scheduling and prominently displayed at the point of service. Patients must be informed that facility and professional service charges are separate and additive, so that they can make meaningful choices about where to seek care.

Beyond these overarching concerns, which apply to any expansion of site neutral payment implemented outside of budget neutrality, the AMA has specific reservations about the evidentiary basis and design of the imaging without contrast proposal itself. Even if CMS declines to adopt the AMA's recommendations to reinvest these savings in the MPFS, the way the Agency has justified and structured this proposal warrants closer scrutiny before it is finalized. The concerns below address the scope of the codes affected, the strength of the evidence offered by CMS that the targeted volume growth reflects unnecessary migration, and several methodological questions the Agency should resolve before proceeding.

*CMS Should Evaluate the CY 2026 Drug Administration Policy Before Expanding Further*

The AMA is concerned that CMS is expanding its volume control authority to a new category of services each year without pausing to evaluate whether the prior expansions are achieving their intended effects. CMS' own pattern of rulemaking illustrates the problem. When CMS extended this authority to drug administration services in 2026, it relied in part on its assessment that the CY 2019 clinic visit policy "has had a positive impact" (91 FR 41908) on efforts to curb unnecessary volume growth. That is a reasonable way to justify an expansion, but it depends on CMS having evaluated the prior policy before building on it. The CY 2026 drug administration policy took effect on January 1, 2026, only months before this proposed rule was issued. CMS cannot yet have meaningful data on whether that policy has curbed volume growth, shifted care to lower-cost settings, affected beneficiary access, or produced any of the outcomes the Agency intends. Finalizing an imaging without contrast expansion for CY 2027, on the heels of the drug administration expansion, and before either can be evaluated, is inconsistent with the evidence-based, sequential approach CMS has itself described. This concern is heightened by the fact that, as discussed below, the evidence CMS has offered for the imaging proposal specifically does not consistently demonstrate the unnecessary migration the policy assumes. **The AMA urges CMS to defer further expansion of this policy until it has evaluated the impact of the CY 2026 drug administration policy, including its effects on volume, site-of-service, beneficiary cost-sharing, and access to care.**

*Scope of the Proposed Cut Exceeds CMS' Own Evidentiary Basis*

CMS states that 337 HCPCS codes make up the four imaging without contrast APCs for 2026. Of those, only 70 codes, roughly one-fifth, account for over 95 percent of the volume of imaging without contrast services furnished in excepted PBDs. This same concentration holds in non-excepted PBDs. CMS' prior applications of this volume-control authority were much narrower in scope: the CY 2019 policy was built around a single code (G0463), and the CY 2026 expansion, while covering an entire APC family, applied to a comparatively small and clinically homogeneous set of drug administration codes (61 HCPCS codes in total). The 337 codes captured by this proposal are not only far more numerous but span a far wider

range of modalities and clinical circumstances. The concentration of volume in a small fraction of these codes is itself evidence of that heterogeneity: it shows that the four imaging without contrast APCs group together services with materially different utilization patterns and, in all likelihood, materially different clinical circumstances driving where they are furnished. CMS has not addressed whether it remains appropriate to treat so heterogeneous a clinical family as a single unit at this scale, or whether the range of services now captured instead warrants a narrower or more staged approach. **The AMA urges CMS to explain why the imaging-without-contrast APCs, given their size and clinical heterogeneity, are an appropriate vehicle for this authority, and, at a minimum, to disclose the code-level utilization data underlying this proposal so that the public can evaluate whether a uniform payment reduction is warranted across the full range of services it would affect.**

*CMS' Own Examples Do Not Consistently Show the Migration the Policy Assumes*

The volume control theory CMS relies on assumes that a payment differential drives the site-of-service decision; namely, that the same patient encounter shifts from a physician office to a PBD because of relative reimbursement rather than clinical need. If that theory holds uniformly across the codes captured by this policy, one would expect a broadly consistent pattern: PBD growth accompanied by a corresponding decline in office volume. CMS' own illustrative examples show no such uniformity. Of the six codes CMS cites, three (71250, 70551, 76536) show office volume growing alongside PBD volume; a fourth (77080) shows office volume essentially unchanged; only two (71045, 76641) show declining office volume.

| Code | Description | Office Rate | OPPS Rate | OPD Premium | PBD Volume, 2016 – 2025 | Office Volume, 2016 – 2025 |
|---|---|---|---|---|---|---|
| 77080 | Dxa bone density axial | ~$30 | ~$106 | 253% | +55% | -0.5% |
| 71045 | X-ray exam chest 1 view | ~$17 | ~$88 | 417% | +92% *(2018-2025)* | -33% *(2018-2025)* |
| 71250 | Ct thorax dx c- | ~$83 | ~$106 | 27% | +72% | +33% |
| 70551 | Mri brain stem w/o dye | ~$127 | ~$243 | 91% | +41% | +14% |
| 76536 | Us exam of head and neck | ~$82 | ~$106 | 29% | +48% | +4% |
| 76641 | Ultrasound breast complete | ~$66 | ~$106 | 60% | +52% | -25% |

This heterogeneity itself is the problem with the remedy CMS has proposed. A policy premised on site-of-service diversion should be targeted at the codes and services where diversion is actually occurring, not applied uniformly across an APC family where CMS' own examples show different utilization dynamics at play, which is a concern consistent with the disproportionality already noted above, where 70 of the 337 affected HCPCS codes account for over 95 percent of the relevant volume.

*The Underlying Research CMS Relies on Identifies a Different Mechanism and a Different Solution*

CMS cites Whaley et al. (2021), which found that after a primary care physician group was acquired by a hospital or health system, imaging volume in hospital-based settings rose while non-hospital volume fell by nearly the same amount (a net increase of only 1.5 procedures per 1,000 beneficiaries against gross shifts more than 15 times that size). The AMA does not dispute this finding and does not oppose site neutral payment as a general direction for addressing the spending growth that this literature documents. But the same research also found that, for imaging tests specifically, the shift in referral patterns occurred immediately upon a change in ownership, with no pre-existing trend in hospital-based volume or Medicare spending before the acquisition. This indicates that site-of-service for imaging is driven by the

acquiring institution's referral patterns following consolidation, not by a marginal comparison of reimbursement rates by an independent referring physician. A payment cut at the excepted PBD does not reverse an acquisition that has already occurred, and it does not restore the referring physician's independence or the patient's access to a lower-cost office setting once that office no longer exists as an independent practice; it captures budgetary savings from volume this literature attributes to consolidation, without addressing consolidation's cause.

That cause is substantially the same one the AMA has raised in every comment letter on this issue since 2018: MPFS rates that have not kept pace with the cost of operating a practice create direct financial pressure for physicians to sell to hospitals and health systems. If referral steering after consolidation, not price-shopping, is what drives the volume this policy targets, as CMS' own cited research indicates, the more durable solution is to reinvest savings from this policy into MPFS rates sufficient to sustain independent practice, rather than to rely on an excepted-PBD rate cut that addresses only the downstream financial consequence.

*Persistent Growth in Already Price-Equalized Settings Warrants Further Explanation*

CMS notes that non-excepted PBDs, which have been paid MPFS-equivalent rates for these same codes since 2017, have grown steadily in recent years, even as excepted PBDs continue to account for 75 to 82 percent of combined PBD volume for the highest-volume services. CMS reads this concentration as evidence that the payment differential is doing meaningful work. The AMA agrees that is one reasonable reading, but the persistence of growth in a setting already paid at the MPFS-equivalent rate also suggests that price equalization alone has not been sufficient to arrest volume growth in the hospital-affiliated PBD channel generally, whether excepted or not. To the extent this growth reflects referral patterns established by hospital ownership of the referring practice, paying a lower rate at the excepted PBD may reduce Medicare's spending on that volume without reducing the volume itself or restoring the office as a genuine alternative for the affected beneficiary.

*CMS Should Disclose Whether Its Analysis Accounts for Changes in FFS Population Composition*

CMS states that per-beneficiary utilization of the top 70 imaging without contrast codes in excepted PBDs grew by over 67 percent between 2016 and 2025 even as Part B fee-for-service enrollment declined by approximately 17 percent and offers this as evidence that the growth is not attributable to enrollment trends. This comparison does not appear to account for the substantial growth in Medicare Advantage enrollment over the same period, which draws disproportionately from healthier beneficiaries and leaves the remaining fee-for-service population systematically older and sicker relative to the fee-for-service population a decade earlier. **The AMA urges CMS to disclose whether, and how, its analysis controls for this selection effect before relying on the 67 percent figure as evidence of induced demand.**

*Interaction with the Multiple-Imaging Composite Policy and the Statutory Imaging Payment Cap*

The AMA is concerned that CMS proposes to apply the 40 percent relativity adjuster not only to the four standalone imaging without contrast APCs (5521, 5522, 5523, and 5524), but also to APCs 8004, 8005, and 8007, which already provide a single bundled payment, discounted relative to the sum of individual APC payments, when a hospital furnishes multiple same-family imaging procedures in one encounter. Layering a flat 40 percent adjuster on a rate already discounted for bundling efficiency compounds two separate reductions in a manner not derived from what a freestanding office actually collects for furnishing the same combination of services in a single visit. CMS should disclose the methodology it used to translate the composite APC rate into a MPFS-equivalent figure and confirm that the resulting rate does not fall below actual MPFS payment for the same combination of services.

The AMA also requests that CMS clarify how this proposal interacts with the existing limit on imaging payments under section 5102(b) of the Deficit Reduction Act of 2005, which caps the technical component of the MPFS payment for many imaging services, including CT, MRI, and nuclear medicine studies, at the OPPS payment amount for the same service. Where that cap applies, the actual MPFS payment for a given code is already set equal to the OPPS rate rather than the lower RVU-based amount. As a result, a uniform 40 percent adjuster may not achieve the MPFS-equivalence CMS intends for codes subject to the cap. **The AMA therefore recommends that CMS use, code-specific MPFS non-facility payment amounts, adjusted as necessary to account for the section 5102(b) cap, rather than a single percentage applied uniformly across all affected codes.**

*Rural Sole Community Hospital Exemption.*

The AMA supports the proposed exemption for rural SCHs, consistent with CMS' approach to the clinic visit and drug administration policies. Most services captured by the imaging without contrast APCs are widely available in freestanding imaging centers and physician offices in most markets, which mitigates some of the access concerns the AMA has raised in connection with other site neutral proposals. The AMA nonetheless urges CMS to monitor imaging volume and access in rural and underserved communities more broadly, including excepted PBDs that do not meet the SCH definition, and to report on these effects in the CY 2028 rulemaking cycle.

### C. Services That Will Be Paid Only as Inpatient Services

**Recommendations**

- The AMA supports furnishing services in the most clinically appropriate and, where possible, lower-cost setting, and supports removing services from the Inpatient Only (IPO) list where service-specific data and medical evidence demonstrate that a service can be safely furnished in the outpatient setting for the Medicare population. However, the AMA urges CMS to ground each phase of the transition in evidence, developed in consultation with the relevant interested parties, to let clinical and payment system readiness rather than a fixed schedule determine the pace of removal, and to safeguard physicians' clinical judgment by strengthening the medical review protections that apply to services removed from the list.

For CY 2027, CMS proposes to remove 637 services across eleven clinical families (auditory, digestive, endocrine, female genital, hemic and lymphatic, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary) as the second phase of the three-year transition to eliminate the IPO list that CMS finalized in the CY 2026 OPPS/ASC final rule.

The IPO list was established in 2000 to identify services for which Medicare pays only when they are furnished in the inpatient setting, based on the invasive nature of the procedure, the beneficiary's underlying condition, or the need for at least 24 hours of postoperative recovery. For nearly two decades, CMS reviewed the list annually and, through rulemaking, removed or added individual services based on service-specific data and medical evidence, applying five longstanding removal criteria. In 2021, CMS first proposed to eliminate the IPO list entirely over three years, beginning with 298 codes, including 266 musculoskeletal services. In 2022, CMS halted that elimination and, following clinical review, returned most of the 2021-removed services to the IPO list, and it codified the five removal criteria at 42 CFR 419.23. CMS maintained the IPO list on this basis through 2025. In 2026, CMS reinstated the wholesale approach, finalizing elimination of the IPO list over a new three-year transition beginning with 285 mostly musculoskeletal services, and it eliminated the codified removal criteria as a conforming change.

The AMA fully supports providing physicians with autonomy to determine, together with their patients, the most appropriate site-of-service for a given procedure. This principle is reflected in longstanding AMA policy that Medicare and Medicare Advantage should not deny or reduce payment for a procedure based solely on the site-of-service, provided the procedure is medically necessary and can be safely furnished in that setting. Because the site-of-service determination is a clinical judgment belonging to the physician and patient, it should not be dictated by CMS, by hospitals, or by payers, whether directly or indirectly through the financial consequences of payment and coverage policy. CMS has repeatedly recognized that this determination is a complex medical judgment that belongs to the physician. The Agency has stated that services removed from the IPO list remain payable in the inpatient setting, and that the outpatient setting should not become the default simply because a service has been removed. The AMA strongly agrees and appreciates CMS' clear articulation of these principles. Deference to physicians' case-by-case, beneficiary-specific judgment is the standard the AMA has long urged, and our recommendations below are offered in service of that same principle.

In practice, however, hospitals and payers often influence site-of-service determinations, and the burden then falls on the physician to justify why a particular patient requires a procedure in the inpatient setting. AMA policy is meant to guard against exactly that burden-shift. Payment for a clinically appropriate admission should not depend on second-guessing the physician's judgment about where care is medically necessary for a given beneficiary. While a service remains on the IPO list, the physician's admission decision is categorically appropriate for payment under Part A and is not subject to patient status medical review based on site-of-service. Once a service is removed, that protection is withdrawn. The AMA is therefore concerned that removing services from the IPO list before clinical practice has genuinely migrated to the outpatient setting will pressure physicians to furnish outpatient care for patients who, in their clinical judgment, require inpatient care. The physician is left to carry the documentation burden, the financial risk of a denied claim, and the clinical accountability for the outcome.

*Evidentiary Standard for Removal*

In 2026, CMS supported removal of musculoskeletal services with service-relevant evidence: the accelerated decline in short-stay inpatient admissions for these procedures during the COVID-19 public health emergency, the near doubling of Medicare ASCs specializing in orthopedic or musculoskeletal services between 2016 and 2021, CMS' prior evidence-based removal of total knee and total hip arthroplasty, advances in minimally invasive technique and expedited rehabilitation protocols, and the availability of comprehensive APCs to support appropriate outpatient payment (90 FR 53783 through 53784). In contrast, the 2027 proposal offers no comparable analysis for the 637 services now proposed for removal. These 11 clinical families are considerably more heterogeneous than the 2026 cohort, with widely varying risk profiles and postoperative needs, and the proposed rule does not appear to include service-specific utilization data, clinical literature, or outcomes evidence showing that these services have migrated to the outpatient setting or can be furnished there safely for the typical Medicare beneficiary. The AMA does not contend that none of these services are appropriate for removal—many likely are, and we support their removal where the evidence supports it. **The AMA urges CMS to hold each phase of this transition to the same evidentiary standard it applied in 2026, developed in consultation with the relevant national medical specialty societies, and to defer removal of any service or clinical family for which that evidence has not been developed.**

The AMA also notes that CMS itself has acknowledged that the services remaining after 2027, including cardiovascular, neurological, and solid organ, intestinal, and islet cell transplant procedures, are more clinically complex and may require new or restructured APCs to support appropriate outpatient payment. If this work is not complete, a predetermined calendar should not drive their removal. The AMA urges CMS to let the evidence and the readiness of the payment infrastructure, rather than the calendar,

determine the pace of removal, and urge CMS to state expressly that it will slow or extend the transition where clinical review or APC development for a given service or family is not complete.

*Medical Review Exemption*

The AMA appreciates CMS' continuation of the exemption from certain medical review activities for services removed from the IPO list, and its clarification that this is an exemption from review activity rather than an exception to the two-midnight rule, with which providers must continue to comply. We also support CMS' decision to announce the end of an exemption through notice-and-comment rulemaking rather than subregulatory guidance. Under current policy, the exemption for a given procedure lasts until CMS determines, based on claims data, that the procedure is furnished more than 50 percent of the time in the outpatient setting in a calendar year. For the musculoskeletal services already migrating to the outpatient setting, that threshold may be reached relatively soon, and the residual inpatient cases are comparatively few and lower risk. The exposure is greater for the more complex services in later phases; because a substantial share of these patients will continue to require inpatient care for years to come, the exemption will remain in place for an extended period, and when review does resume, it will fall most heavily on physicians caring for the medically complex patients who genuinely require inpatient care.

Once an exemption ends and patient status review resumes, the AMA policy stated above supplies the governing standard: a physician's clinically correct decision to admit a particular beneficiary as an inpatient must not produce a denied or reduced claim based solely on the fact that the service has become more commonly furnished in the outpatient setting across the Medicare population. This exposure is not confined to traditional Medicare. As services are removed from the IPO list, Medicare Advantage plans may treat the outpatient setting as the presumptive site of care in their own coverage and utilization management determinations. Consistent with the requirement that Medicare Advantage plans apply the two-midnight rule and impose no coverage criteria more restrictive than traditional Medicare, CMS should confirm that Medicare Advantage plans are not denying or reducing payment for medically necessary inpatient admissions based solely on the site-of-service.

To protect physicians and patients as the transition proceeds, **the AMA recommends that CMS:**

- Confirm that every determination ending an exemption, not just the first, will proceed through notice-and-comment rulemaking, given the burden and financial risk that attach once review resumes.
- Adopt a defined transition period of at least two years following any determination that a service is more commonly furnished in the outpatient setting, before medical review activity resumes for that service, mirroring the exemption period CMS applied to earlier, evidence-based removals.
- Actively monitor the medical review process as it resumes and make available data on review activity, denial rates, and appeal outcomes. CMS has acknowledged that a procedure being more commonly furnished in the outpatient setting across the Medicare population says nothing about the individual patient who requires inpatient care, and that the case-by-case exception remains available for those patients. We urge CMS to ensure, through clear guidance to MACs, that the resumption of review does not create pressure against medically necessary inpatient admissions.

Finally, the AMA reiterates two concerns raised during the CY 2026 rulemaking that CMS acknowledged but deferred as outside the scope of that rule. First, because Medicare coverage of skilled nursing facility care requires a prior inpatient stay of at least three consecutive days, shifting surgical care to the outpatient setting may leave some beneficiaries unable to satisfy that requirement. CMS' response to this concern that it does not expect these patients to need such care, does not resolve the concern for the patients who do. Second, shifting healthier, less complex patients to the outpatient setting leaves a more

complex residual inpatient population, and CMS should assess whether existing Medicare Severity Diagnosis Related Group rates adequately reflect that shift. The AMA also continues to urge CMS to provide clear information on how services removed from the list will be reimbursed in the outpatient setting relative to the cost of furnishing them there.

### D. CY 2027 OPPS Payment Methodology for 340B Purchased Drugs Based on Survey Results

The AMA supports CMS' proposal to reduce Medicare payment for 340B-acquired drugs from average sales price (ASP) plus 6 percent to ASP minus 33.4 percent. The proposal would reduce a payment disparity that advantages hospital-owned sites over independent physician practices furnishing the same physician-administered therapies. Independent physician practices generally do not have access to 340B discounts and therefore do not capture the same spread between Medicare payment and the price paid to acquire a drug. Allowing 340B hospitals to retain that spread can make the hospital outpatient setting more financially attractive for drug-intensive services and reinforce broader incentives for hospitals to acquire physician practices and shift care into higher-cost settings.

This concern is particularly important as the number of physicians practicing independently continues to decline. The AMA has repeatedly warned that when care moves from independent physician practices into higher-cost hospital settings, patients and the Medicare program pay more and competition declines. Medicare payment policy should not compound these pressures by preserving a drug payment advantage that depends on whether the entity furnishing the drug has access to 340B pricing. CMS' proposal appropriately narrows that disparity while continuing to recognize the substantially lower acquisition prices available through the 340B Program.

CMS' acquisition cost survey provides a strong basis for this change. The survey found substantial differences between the prices hospitals pay for drugs acquired through the 340B Program and drugs acquired outside the program. Based on those results, CMS proposes to pay ASP minus 33.4 percent for most separately payable 340B-acquired drugs beginning in 2027. CMS estimates that the proposal would reduce beneficiary drug payments by approximately $1.15 billion in its first year. In some cases, identified through the survey, a beneficiary's 20 percent cost-sharing obligation under the existing payment methodology exceeded the hospital's entire acquisition cost for the drug. Medicare should not require beneficiaries to pay cost sharing calculated from a payment amount that substantially exceeds what the hospital paid to obtain the drug.

The AMA particularly supports applying the proposed 340B payment adjustment to drugs furnished in nonexcepted off-campus PBDs. These departments remain hospital-owned and may have access to 340B acquisition discounts even though Medicare generally pays for their services under a methodology intended to approximate payment in the physician office setting. Leaving 340B-acquired drugs furnished in these departments at ASP plus six percent would preserve a substantial payment advantage based solely on hospital ownership, and undermine the purpose of moving toward site neutral payment. CMS similarly concludes that failing to apply the adjustment would create distorted incentives for hospitals to furnish 340B drugs through these departments. Because the proposed reduction for nonexcepted off-campus PBDs would not be budget neutralized, CMS estimates that it would save the Medicare Part B Trust Fund approximately $735 million and reduce beneficiary copayments by approximately $185 million in 2027.

More broadly, CMS should continue examining Medicare payment policies that create different financial incentives for the same service based primarily on site of care or ownership. Payment differentials can influence organizational decisions about where services are furnished and contribute to consolidation without improving the care patients receive. The AMA therefore encourages CMS to consider the

proposed 340B payment adjustment as part of its broader efforts to reduce unnecessary site-of-service payment disparities while ensuring that savings attributable to these reforms benefit patients and the Medicare program.

### E. Proposed Payment Rates for Skin Substitute APCs

**Recommendations**

- The AMA supports CMS' proposal to maintain the CY 2026 skin substitute payment framework unchanged for CY 2027 while additional post-implementation claims data accumulate, and urges CMS to closely monitor beneficiary access to clinically appropriate skin substitute products, particularly for complex, non-healing chronic wounds, as this significant restructuring takes full effect.

In the CY 2026 OPPS/ASC final rule, CMS fundamentally restructured Medicare payment for skin substitute products furnished in the hospital outpatient setting, unpackaging payment for these products from their associated application procedures and paying for them separately as incident-to supplies. Only skin substitute products licensed as biologics under Section 351 of the Public Health Service (PHS) Act continue to be paid under the ASP-based methodology. All other skin substitute products (human cells, tissues, and cellular and tissue-based products regulated under Section 361 of the PHS Act, devices cleared through the FDA's 510(k) pathway, and devices approved through premarket approval (PMA)) were reassigned to one of three new APCs (6000, 6001, 6002) and given a new status indicator, "S1." For CY 2026, CMS applied a single, harmonized payment rate of $127.14 per square centimeter across all three APCs, with a parallel policy extended to the ASC setting through new payment indicator "S2." CMS finalized a closely related, but not identical, policy for the non-facility setting in the CY 2026 MPFS final rule, discussed further below.

For CY 2027, CMS proposes no substantive changes to the OPPS skin substitute payment framework, stating that it does not yet have sufficient claims experience reflecting the CY 2026 reforms to appropriately recalibrate payment rates for the three skin substitute APCs, and that it intends to use a full year of CY 2026 claims data to inform any future rulemaking on this topic.

**The AMA supports maintaining current OPPS rates for CY 2027.** CMS' stated rationale that it should not recalibrate skin substitute payment rates before adequate post-implementation claims data are available is consistent with the AMA's longstanding position that CMS should ground major payment methodology changes in adequate, representative utilization and cost data rather than act on incomplete or projected information. We agree that CY 2027 is too soon to recalibrate rates that took effect only months earlier, and we support CMS' proposal to hold the current framework steady while a full year of claims experience develops.

The AMA's support for maintaining current rates should not be read as unconditional comfort with this policy area, however, and we urge CMS to monitor closely to confirm that the CY 2026 restructuring is achieving its intended effect without producing unintended or adverse consequences. The sustained payment differential between OPPS' historically bundled treatment of skin substitutes and the non-facility setting's separate, ASP-based payment is understood to have contributed to a substantial shift of skin substitute utilization toward the physician office over the past decade. The AMA has raised this general concern before. In comments on the CY 2026 MPFS proposed rule, the AMA agreed that payment differentials between facility and non-facility settings create real unfairness for physicians and reiterated its longstanding support for Medicare payment policies that are site neutral without lowering total Medicare payments. The AMA supports that same principle here: skin substitute payment should not vary

simply because of where a product happens to be applied, and closing the longstanding gap between OPPS and non-facility payment is a reasonable goal. At the same time, closing that gap is itself a significant intervention into a market that has already shown it will respond to payment incentives, and the AMA urges CMS to watch closely for new, unanticipated distortions as this policy takes full effect.

This vigilance is not merely a hospital-side concern, and CMS' own rulemaking underscores why. In finalizing the parallel non-facility skin substitute policy, CMS acknowledged that CY 2026 implementation relied on nominal, placeholder utilization figures rather than actual claims experience, and stated that "changes in payment rates for these particular codes will be incorporated into MPFS relativity once we use claims data from 2026," meaning the real effect of this policy on the MPFS will not be felt until the CY 2027 and CY 2028 rulemaking cycles (90 FR 49968). As the AMA cautioned in its CY 2026 MPFS comments, because the MPFS operates as a single, budget neutral system, that delayed effect could be significant for practice expense payment across physician services entirely unrelated to skin substitutes or wound care. The AMA reiterates that concern here and urges CMS to take it into account, alongside the OPPS-side monitoring discussed above, as it considers any future recalibration of skin substitute payment under either system.

**The AMA also urges CMS to treat cross-setting payment alignment as an ongoing priority as this policy matures.** Even the harmonized CY 2026 rates were not identical across settings ($127.14 per square centimeter under OPPS versus $127.28 under the MPFS), which is a reminder that maintaining alignment between systems requires sustained attention rather than a one-time fix. Because OPPS and the MPFS are recalibrated separately and on different data and different rulemaking timelines, the AMA urges CMS to monitor whether a new gap between the two systems emerges in future years and to address it promptly if it does, given the potential for exactly this kind of gap to reintroduce site-of-service distortions unrelated to clinical need.

Finally, the AMA asks that CMS commit, as part of any future rulemaking, to differentiate skin substitute payment rates by FDA regulatory category, and to report on utilization and cost trends across OPPS and MPFS claims data jointly, rather than evaluating the two payment systems in isolation, given how closely linked they now are for this product category.

### F. OPPS Payments for SaMS Diagnostic Services

**Recommendations**

- The AMA supports CMS' proposal to change the terminology from SaaS to SaMS and the related interim CY 2027 payment approach, provided that SaMS functions as an interim Medicare payment designation rather than a parallel clinical or coding taxonomy. Additionally, CMS should draw on existing frameworks, including CPT Appendix S and the CPT Editorial Panel's ongoing Clinically Meaningful Algorithmic Analyses work, so that Medicare and coding classifications do not diverge in ways that increase administrative burden and mispricing risk.
- The AMA does not support CMS' proposal to remove SaMS analyses performed on laboratory tests from the CLFS and assign them to New Technology APCs under the OPPS. CMS should withdraw the proposed 10-code list pending a code-by-code technical review, in consultation with the relevant interested parties.

Software-based technologies, including clinical decision support software, clinical risk modeling, computer-aided detection (CAD), and other artificial intelligence (AI)-enabled tools are increasingly used to support diagnosis and treatment planning across care settings. CMS has been evaluating how to develop a comprehensive and consistent approach to payment for these technologies across multiple

rulemaking cycles, issuing two prior comment solicitations (87 FR 72035 through 87 FR 72036, 89 FR 94129 through 89 FR 94131). A central challenge, as stated by CMS, is that "current Medicare Part B payment systems for SaMS, including in the OPPS, are primarily designed to pay for services that rely on material resources, rather than technologies whose value is driven by proprietary algorithms and scalable, non-material costs." (91 FR 41919) This mismatch complicates valuation and raises transparency concerns given subscription, license, and per-use ("per click") arrangements. As coding and utilization for these services continue to grow, CMS has sought to move toward a more standardized approach that reduces payment variation across similar technologies.

For CY 2027, CMS proposes four changes regarding software-based medical services with algorithmic analyses. We address each of these four proposals below.

*Terminology Change from SaaS to SaMS*

CMS proposes to replace the term SaaS with SaMS to refer to software-based technologies that support clinical decision-making through algorithmic analysis, including those providing clinical or diagnostic functionality.

**The AMA supports CMS' proposal to adopt the term SaMS.** Because SaMS is widely used in other industries to describe general cloud-based computing models unrelated to healthcare, adopting a health-care-specific term reduces ambiguity and more accurately reflects the medical function these technologies perform for Medicare payment purposes.

At the same time, the AMA emphasizes that the SaMS designation should function as an interim Medicare payment classification, not as a parallel clinical or coding taxonomy that conflicts with the terminology, instructions, and service relationships established through the CPT code set. The involvement of software does not, by itself, establish the nature of a service, the resources it requires, the role of the physician or other qualified healthcare professional, or the appropriate Medicare payment system. Accordingly, a SaMS designation should not be construed to establish coverage, medical necessity, clinical equivalence among grouped services, or a categorical entitlement to separate payment.

This proposal is closely related to the AMA's work, through the CPT code set, to give AI-enabled services a recognized clinical identity, and the AMA encourages CMS to build on this existing framework, which would help keep Medicare and coding classifications aligned and reduce administrative complexity. The AMA would welcome the opportunity to share the CPT Editorial Panel's expertise, along with that of other stakeholders, toward that end. CPT Appendix S, developed by the CPT Editorial Panel and its Digital Medicine Coding Committee (DMCC), distinguishes assistive, augmentative, and autonomous applications according to the function performed and the relationship of the technology to the physician or other qualified healthcare professional. The DMCC is also considering a Clinically Meaningful Algorithmic Analyses framework to support more consistent identification and description of algorithmic analyses; that work remains under development and should not be characterized as finalized CPT coding.

Standardized nomenclature and coding are prerequisites to appropriate recognition and payment. Before payers and CMS can recognize a clinical AI service for reimbursement, including through pathways designed to support emerging innovations such as the New Technology APC process, they need a standardized way to identify what service was performed. Recognized codes supply that identifier, and reporting these services consistently produces the utilization data on which transparent, evidence-based valuation ultimately depends. Fragmenting or duplicating that nomenclature through a separate Medicare

classification would add administrative burden and increase the risk of mispricing and program integrity concerns.

*Interim Assignment of SaMS Technologies to New Technology APCs*

As an interim payment policy for CY 2027, CMS proposes to designate 36 HCPCS codes as SaMS and to reassign 21 of those codes that are currently separately paid under clinical APCs (status indicator "S") to New Technology APCs at rates that closely align with their CY 2026 payment. For SaMS technologies already assigned to New Technology APCs for CY 2026, CMS proposes to continue those assignments. CMS reasons that the existing clinical APC structure does not adequately accommodate SaMS and that New Technology APCs are the more appropriate temporary placement while it gathers data and evaluates long-term approaches, consistent with the Agency's historical use of New Technology APCs for services lacking sufficient claims for cost data.

**The AMA supports CMS' proposed interim policy to assign designated SaMS technologies to New Technology APCs for CY 2027, and to maintain the current New Technology APC assignments for SaMS technologies already paid under those APCs for CY 2026.** This approach promotes payment stability and predictability for these services while CMS continues to develop a longer-term methodology, and it appropriately avoids disruption to patient access.

At the same time, the AMA encourages CMS to address the more fundamental question that its proposals only begin to reach how Medicare payment systems should account for and pay for these technologies on a long-term basis. CMS has been examining this issue across multiple rulemaking cycles and has not yet arrived at a uniform, comprehensive solution, and the current approach remains necessarily ad hoc. The AMA does not object to an interim, incremental approach at this stage, because a stable coding framework for these technologies is still maturing, and a meaningful and accurate payment framework cannot be constructed until the underlying services are consistently described. The AMA therefore emphasizes a general principle: Medicare needs both a uniform way of describing SaMS technologies and a payment methodology that reimburses them appropriately.

Rather than endorsing any single long-term payment construct at this time, the AMA stands ready to serve as a resource to CMS as it continues to work through these issues in future rulemaking, so that the resulting coding and payment approach is coherent across care settings and specialties and reflects the perspectives of the physicians and other stakeholders who furnish these services.

*New Status Indicator "O1" for SaMS Technologies*

To distinguish SaMS from other services assigned to New Technology APCs, CMS proposes to create status indicator "O1" (Software as a Medical Service, paid under OPPS; separate APC payment), which would carry the same payment specifications as status indicator "S." CMS also seeks comment on whether a status indicator mirroring "T" (Procedure or service subject to multiple procedure discounting) would be more appropriate. For SaMS currently conditionally packaged (status indicator "Q1"), or not separately paid (status indicators "N", "M," or "E1"), CMS proposes to maintain the current assignments to avoid disrupting patient access.

**The AMA supports CMS' proposal to create status indicator "O1" and to assign designated SaMS technologies to it.** Because "O1" would carry the same payment specifications as status indicator "S," it preserves separate payment for these services, which promotes payment stability while CMS develops a more comprehensive long-term payment approach. A dedicated status indicator also improves the

transparency and traceability of SaMS utilization, which will support the data collection necessary to inform future policy.

*SaMS Analyses Performed on Laboratory Tests*

CMS proposes to remove 10 HCPCS codes describing SaMS analyses performed on laboratory tests from the CLFS and assign them to New Technology APCs under the OPPS, crosswalking to APC cost bands that approximate current CLFS rates, and to similarly assign any future such codes to New Technology APCs. CMS reasons that these secondary, stand-alone algorithmic analyses are "other diagnostic tests" under section 1861(s)(3) of the Social Security Act rather than "diagnostic laboratory tests," do not require performance by a CLIA-certified laboratory, and should be treated consistently with other SaMS technologies regardless of setting.

**The AMA does not support CMS' proposal to remove SaMS analyses performed on laboratory tests from the CLFS and assign them to New Technology APCs under the OPPS.** While the AMA appreciates CMS' interest in treating fundamentally similar services consistently across care settings, the proposal rests on a descriptor-based method of classification that is not a reliable basis for reassigning services or changing the payment system that applies to them.

The AMA is concerned that CMS identified the 10 codes proposed for removal from the CLFS principally by examining whether their descriptors included a laboratory method or described a computer analysis. A CPT descriptor cannot always be evaluated in isolation. Proper classification requires consideration of the full code family, introductory guidelines, parenthetical instructions, add-on relationships, the underlying source data, data acquisition and preparation, quality control activities, the algorithmic output, and any required professional interpretation or management.

The proposed list itself illustrates the limitations of descriptor-based classification. Several listed codes expressly describe gene-expression analysis, tumor-cell culture, tissue-based analysis, or other activities that may involve laboratory processes in addition to an algorithmic component. For example, CPT code 81416 *Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)* describes comparator exome sequence analysis and is an add-on code that must be interpreted in relation to its primary service. Such services should not be treated as freestanding, secondary software analyses without a detailed technical assessment of the complete service described.

Whether a service is subject to CLIA requirements must likewise be determined from the actual activities involved in furnishing the service, not solely from whether an algorithm could theoretically be executed outside a CLIA-certified laboratory. Data preparation, specimen-related quality controls, validation, analysis, and reporting may remain integral to the service even when the final computational step can be performed separately. CMS grounds the proposal on the view that these secondary analyses are "other diagnostic tests" under section 1861(s)(3) of the Act rather than "diagnostic laboratory tests," and that an entity performing only algorithmic analyses of previously generated data may not qualify as a laboratory under 42 CFR 493.2 or require CLIA certification under section 1861(s)(17) of the Act (91 FR 41926). Applying that framework accurately to any individual service requires clinical and laboratory expertise that a deliberate, code-by-code technical review is best positioned to supply.

**Accordingly, the AMA recommends that CMS withdraw the proposed 10-code list and, before changing the payment system applicable to any individual code, consult the relevant stakeholders, including the code applicants, clinical and laboratory experts, CMS' own Advisory Panel on Clinical Diagnostic Laboratory Tests, and the CPT Editorial Panel.** CMS should not remove any

service from the CLFS until it determines, through that process, that the algorithmic analysis can be safely and appropriately separated from the CLIA-certified laboratory that generated the underlying data. More broadly, CMS should establish transparent criteria that separately evaluate the data acquisition, laboratory, data-preparation, algorithmic analysis, interpretation, and treatment management components of these services, and should work with stakeholders to develop a payment framework that recognizes the unique characteristics of SaMS technologies. Moving these services prematurely risks mischaracterizing integrated laboratory services, disrupting established payment, and locking in a placement before the definitional and valuation questions are resolved.

### G. Prior Authorization Botulinum Toxin Injection Codes

CMS proposes to expand the hospital outpatient department (HOPD) prior authorization (PA) program to eight additional botulinum toxin injection codes beginning July 1, 2027. The Agency bases this proposal on what it characterizes as an unnecessary increase in utilization, citing a 42.8 percent increase in claims for these services between 2017 and 2024 while overall HOPD claim volume declined by 8.3 percent. The AMA recognizes that PA can have an appropriate, targeted role when there is evidence of potentially inappropriate utilization. We do not believe, however, that the analysis presented in the proposed rule is sufficient to establish that the increase in these services represents inappropriate utilization. Utilization of a particular treatment could legitimately grow faster than aggregate HOPD utilization for several reasons. Although CMS indicates that it considered legitimate explanations for the increase, including changes in clinical need and new FDA-approved indications, it is unclear whether the Agency examined utilization by individual service and clinical indication, quantified the contribution of new FDA-approved indications, or determined how much of the observed growth remained unexplained after accounting for these factors.

**Accordingly, before finalizing this policy, we urge CMS to closely examine whether the observed growth reflects inappropriate utilization or legitimate changes in clinical practice.** Specifically, CMS should ensure that its analysis examines utilization by individual service and clinical indication and accounts for changes in the population eligible for treatment, FDA-approved indications, and clinical guidelines. CMS should also make these findings publicly available so stakeholders can evaluate the basis for the proposed PA requirement.

If CMS nevertheless finalizes PA for these additional services, the AMA strongly urges the Agency to adopt safeguards against treatment disruption. Delays in botulinum toxin therapy can have significant clinical consequences. For conditions such as spasticity and dystonia, botulinum toxin temporarily reduces pathologic muscle overactivity; as its effect wears off, abnormal muscle contraction and tone can recur, leading to renewed symptoms and loss of functional gains. Given the potential for delayed treatment to exacerbate symptoms and reverse clinical progress, CMS should incorporate two key protections into any final PA policy.

**First, the Agency should allow a single PA approval to cover multiple administrations of botulinum toxin therapy.** Under the existing HOPD program, CMS requires a new PA request for each botulinum toxin procedure, even when a patient receives the same treatment on a predictable schedule and the next treatment occurs within 120 days of the previous affirmation. For a patient treated approximately every 12 weeks, this requires four separate PA requests each year for the same course of treatment. There is little medical justification for requiring a new PA for each administration once medical necessity for the course of therapy has been established. Instead, repeated PA imposes additional administrative burden on physicians and hospitals while creating repeated opportunities for treatment delays. This approach also differs from the practices of other payers, which commonly authorize botulinum toxin therapy for periods encompassing multiple administrations. CMS should align its policy with this more rational approach and

authorize the full course of recurring botulinum toxin therapy for at least 12 months once medical necessity has been established.

**Second, CMS should require Medicare Administrative Contractors (MACs) to issue PA decisions within no more than 72 hours for standard requests and 24 hours for expedited requests.** Under the existing HOPD program, MACs may take up to seven calendar days to decide a standard request and two business days to decide an expedited request. For patients receiving time-sensitive, recurring therapy, these timeframes can delay treatment long enough for symptoms to return or worsen while authorization remains pending. Such timeframes are also substantially longer than those that CMS allows elsewhere in Medicare. Medicare Advantage organizations (MAOs), for example, must make standard determinations for Part B drugs within 72 hours and expedited determinations within 24 hours. In CMS-0062-P, CMS signaled that it is considering an even faster standard of 24 hours for all drug PA requests for MAOs. The AMA strongly supports CMS' efforts to accelerate PA decisions, and we urge the Agency to adopt the same standards for timely care in its own fee-for-service program, ensuring that beneficiaries have timely access to care regardless of the coverage they choose.

### H. Codification of Section 6225 of the Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status (§§ 413.65 and 419.23)

**Recommendations**

- The AMA supports the identification and transparency objectives of section 6225 and CMS' implementation through a standardized, centralized attestation process, and offers recommendations to ensure accuracy and reduce administrative burden, particularly for small, rural, and independent facilities.
- The AMA also recommends that CMS publish the standardized attestation form for public comment before finalizing it.

Section 6225 of the Consolidated Appropriations Act, 2026 provides that, beginning January 1, 2028, Medicare will not pay under the OPPS or the applicable payment system for items and services furnished by an off-campus outpatient department of a provider unless the department bills under a separate NPI assigned to that department and the main provider has submitted a provider-based attestation within the two-year period ending on the date the services are furnished, with subsequent attestations submitted at intervals the Secretary specifies. CMS proposes implementing these requirements through several changes. First, CMS would add a new provision at 42 CFR 419.23 and make conforming changes to the provider-based rules at 42 CFR 413.65, including an explicit definition of an off-campus outpatient department tied to the 250-yard standard. Second, CMS would replace the current MAC-specific attestation templates with a standardized form submitted through a centralized electronic system. Third, CMS would shift standardized review and initial determination to the MACs, supported by a tiered, risk-based verification process ranging from automated validation to targeted and extended review. CMS also seeks comment on streamlining supporting documentation for providers that attest for multiple off-campus departments.

The provider-based rules at 42 CFR 413.65 establish the conditions under which an off-campus department may be treated as part of a main provider and paid on that basis. Provider-based attestation has been voluntary for roughly a quarter century; section 6225 converts it into a condition of payment and pairs it with a separate NPI requirement so that Medicare can reliably identify the services furnished at, and the facility fees associated with, each off-campus location. An NPI, however, identifies a healthcare provider for purposes of standard transactions. It does not encode ownership, provider-based status,

affiliation, clinical integration, effective dates, or the relationship between an off-campus department and its main provider.

*Identification and Transparency*

**The AMA supports the identification and transparency objectives of section 6225.** The AMA has long been concerned that the payment differential between HOPDs and independent physician practices disadvantages those practices and encourages their acquisition and conversion to higher-paid outpatient departments, and the AMA supports payment that reflects the service furnished, rather than the site at which it is furnished. The AMA likewise supports meaningful transparency for patients regarding the cost of their care, including clear disclosure that facility fees are separate and additive charges. A reliable, location-specific identifier for each off-campus department is a necessary precondition for that transparency, because without it, claims, price transparency files, and beneficiary notices cannot be matched to the site where care was furnished.

*Structured Relationship Data*

**The AMA recommends that CMS preserve the NPI as an identifier and maintain the structured relationship data necessary to interpret it.** The standardized attestation system should establish an explicit parent-child relationship between each main provider and its off-campus departments and should capture the applicable NPIs, legal and doing-business-as names, physical and mailing addresses, department types, provider-based status, effective and termination dates, ownership and affiliation information, verification status, source, and date of last validation. CMS should retain historical relationships so that claims, audits, price transparency data, provider directories, and beneficiary notices can be reconciled to the organizational structure in effect on the date of service.

*System Alignment and Administrative Burden*

**The AMA recommends that CMS align its systems and reuse existing data to reduce administrative burden and improve accuracy.** Updates accepted through the centralized attestation process should be reflected across the Provider Enrollment, Chain, and Ownership System (PECOS), the National Plan and Provider Enumeration System (NPPES), claims-processing systems, price transparency files, and public directories without requiring providers to re-enter the same information. Consistent with its support for reducing unnecessary administrative burden and for the use of consensus data standards to improve interoperability and directory accuracy, the AMA recommends that CMS reuse existing PECOS and NPPES information to prepopulate the attestation form; support batch submission and application programming interfaces for health systems managing multiple departments; provide machine-readable validation results; and establish a correction process for mismatched addresses, names, or effective dates. CMS should consider alignment with the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) National Directory of Healthcare Providers and Services Implementation Guide, provided that the pursuit of interoperability does not delay reliable implementation before the statutory deadline. Accurate directories and the elimination of duplicative data entry benefit physicians and patients directly by supporting correct referrals and continuity of care.

*Payment Consequences of Non-Compliance*

**The AMA recommends that CMS adopt a cure period so that the payment consequence is proportionate to the deficiency.** Section 6225 conditions payment on both a timely, complete attestation and a separate NPI. A department that fails either requirement becomes ineligible for payment altogether rather than being paid at a reduced rate. Because the consequence is a complete denial rather than a rate

adjustment, a correctable or technical deficiency (e.g., a late subsequent attestation, a mismatched address, or a delayed NPI assignment) could result in the loss of all Medicare payment for otherwise qualifying provider-based services, with consequences that ultimately affect patient access. The AMA recommends that CMS establish a defined cure period and a good-faith compliance mechanism, and that it distinguish clearly between substantive non-compliance with the provider-based rules and correctable defects in the attestation itself.

*Impact on Small, Rural, and Independent Facilities*

**The AMA recommends that CMS calibrate the compliance burden to facility size and resources.** The new mandatory attestation, separate NPI enrollment, and periodic re-attestation will fall unevenly across providers, and small, rural, and independent facilities that lack dedicated enrollment and information technology staff will bear a disproportionate share. The AMA recommends that CMS minimize the burden on these facilities through pre-population, consolidated submission, shared documentation, and clear operational guidance, so that the identification requirement does not impede the continued provision of provider-based services in underserved communities. The AMA notes the attendant risk that a burden falling hardest on smaller facilities could accelerate the consolidation that site-of-service payment reform is intended to discourage.

*Review of Standardized Form and Use of the Identifier*

**The AMA recommends that CMS publish the standardized attestation form for public comment before finalizing it and continue to accept attestation under the current process in the interim.** The proposed rule solicits comment on the standardized attestation and estimates the associated collection burden, but the form itself does not appear to have been made available for review. Publishing it would allow the burden estimate and documentation requirements to be evaluated on their merits. Separately, because an NPI does not encode employment, ownership, or compliance, CMS should not treat the separate NPI, standing alone, as evidence of physician employment, clinical affiliation, ownership, or provider-based compliance; those determinations should rest on the structured relationship data and the attestations. This is a matter of data accuracy rather than opacity. The AMA supports transparency regarding healthcare market structure, and the concern is that conclusions drawn from an identifier alone will be unreliable and may misattribute physicians' practice arrangements.

Taken together, these recommendations would fulfill the statutory identification and attestation requirements while producing more accurate and interoperable provider information, calibrating the payment consequence to the nature of the deficiency, and limiting unnecessary administrative burden, particularly for the small and rural facilities, and the independent physicians, whose patients depend on continued access to provider-based services.

## I. Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data

**Recommendation**

- The AMA recommends that CMS pursue standardization that makes hospital price information genuinely comparable across the sites-of-service in which a service may be furnished, including by requiring accurate, current, and sufficiently detailed coding for each reported item or service and clear disclosure of whether the displayed prices reflect facility charges, professional charges, or both.

CMS requests information on how to strengthen the standardization and comparability of the data hospitals disclose under the hospital price transparency regulations. The RFI addresses two components of those requirements: the comprehensive machine-readable file (MRF), and the consumer-friendly display, which a hospital may satisfy either through a shoppable services file or a price estimator tool. CMS frames the request as an implementation of Executive Order 14221, "*Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information,*" and as a continuation of the standardization work reflected in the CY 2026 OPPS/ASC final rule, which required dollar-based encoding of percentage- and algorithm-based charges, a senior-official attestation, and a Type 2 NPI for each hospital. The consumer-friendly display requirements derive from the CY 2020 hospital price transparency final rule, which established the obligation to display 300 shoppable services, including 70 specified by CMS.

The AMA has long supported meaningful price transparency and, in its comments on the CY 2019 and CY 2020 OPPS/ASC proposed rules, urged CMS to help patients compare the cost of a service across the sites at which it may be furnished, while cautioning against imposing new price disclosure burdens on physician practices themselves. That priority reflects the AMA's broader concern that the payment differential between HOPDs and independent physician practices disadvantages those practices, encourages their acquisition and conversion to higher-paid outpatient departments, and raises costs for patients and the Medicare program. As a threshold matter, the AMA emphasizes that meaningful standardization requires more than consistent file formatting; the items and services reported in the MRF and the consumer-friendly display must be represented with accurate, current, and sufficiently detailed coding so that users can determine what a price represents and what is included in or excluded from that price. The AMA offers the following comments with those objectives in mind, and notes that any binding requirements should be established through notice-and-comment rulemaking, rather than an RFI.

*Comparability Across Sites-of-Service*

The single most valuable enhancement CMS could make, from the perspective of patients and the physicians who counsel them, is to structure the hospital data so that an HOPD charge can be compared with the price of the same service in the other settings where it may be furnished. The hospital price transparency regulations reach hospital standard charges, including facility charges billed by HOPDs. A patient's decision, however, is rarely between two hospitals only, and the same service is frequently available in a physician office or ASC at a materially different total cost. Importantly, the comparators for this analysis already exist without any new obligation on physicians: MPFS, OPPS, and ASC rates are published by CMS, and commercial negotiated rates, including those with physicians, are already disclosed by health plans under separate payer transparency in coverage requirements. The gap is therefore not a lack of physician data, but the difficulty of linking hospital charges to those existing comparators.

Accordingly, **the AMA recommends that CMS require hospitals to encode the place of service and setting associated with each standard charge and align the MRF's service identifiers (including CPT and HCPCS codes) with those used across Medicare payment systems, so that data users can reliably match an HOPD charge to the corresponding physician office or ASC rate.** To be clear, the AMA supports achieving cross-site comparability through the design of the hospital data and the use of already public rate information; it does not support extending the hospital price transparency framework, or any comparable price-posting mandate, to physician practices. As the AMA explained in its CY 2019 comments, physicians are not equipped to generate reliable pre-service price or out-of-pocket estimates for every patient and service without an unreasonable administrative burden, and disclosure obligations are best placed on the hospitals and payers that hold the underlying pricing and contract data.

Standardization that improves comparability only among hospitals, without enabling comparisons across care settings, would leave the most consequential price difference invisible to patients.

*Accurate Coding and Clear Disclosure of Facility and Professional Charges*

Meaningful comparison depends first on knowing what a price represents. **The AMA recommends that CMS require each coded item or service in the MRF to identify the applicable code set, the code set edition or version, the effective date, the code, applicable modifiers, units, and whether the reported amount includes the facility component, the professional component, or both.** Without this metadata, users cannot reliably determine whether two prices describe the same service or include the same component, and superficially comparable figures may in fact differ materially in scope.

The facility versus professional distinction is of particular importance to patients and to the physicians who counsel them, and the RFI expressly asks what contextual information consumers need on this point. In the HOPD setting, a patient typically incurs a separate and additive facility fee that would not be charged for the same service in a physician office, and the professional service is often billed separately by the physician and may not appear in the hospital's data at all. A price that does not disclose whether it reflects the facility component, the professional component, or both can materially understate the total expected cost and mislead a patient comparing sites-of-service. **The AMA recommends that the consumer-friendly display state clearly whether a displayed price reflects facility charges, professional charges, or both, and disclose when a separate facility fee applies.** Clear disclosure that facility fees are separate, additive charges are a prerequisite to the clear, accurate, and actionable pricing information that Executive Order 14221 contemplates.

*Preserving Code Relationships and Maintaining the Shoppable Services List*

The current inclusion of CPT code 29826 *Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)* among the CMS-specified shoppable services illustrates the importance of preserving CPT coding relationships. CPT code 29826 is an add-on code and cannot appropriately be reported as a standalone service. Removing the code from the standalone list would be appropriate, but CMS should also address the underlying data design problem by requiring machine-readable representation of add-on, parent-child, and other code relationships necessary to interpret them. The AMA further recommends that CMS require structured fields indicating whether a price applies to a standalone service, an add-on service, a bundled service, or an episode of care, and, where a price represents a package, that the file identify the principal service, the services ordinarily included in the package, material exclusions, and the circumstances under which ancillary services may generate additional charges.

To keep this information accurate over time, CMS should establish an annual process for updating the list of specified services and the associated coding metadata. The process should account for new, revised, and deleted codes; effective dates; successor and replacement relationships; and changes to coding instructions, and it should rely on authoritative code set information rather than expecting hospitals to identify replacement services through descriptor similarity or informal crosswalks. CMS should provide sufficient implementation time before updated requirements become effective. Because these determinations turn on coding conventions and clinical practice, the AMA offers the expertise of the CPT Editorial Panel to assist CMS in maintaining the specified service-level list and the coding metadata on which it depends, and to ensure that any codes referenced are used consistently with their descriptors, guidelines, and add-on relationships.

*Standardizing Contract Terms and Payer Information in the MRF*

The RFI seeks input on standardizing complex contracting terms (e.g., outlier, stop-loss, rate-tiering, and carve-out provisions) that CMS has found are inconsistently encoded, often in free text. **The AMA supports moving such recurring, consequential information out of unstructured free text fields and into standardized, structured data elements with defined valid values, so that users can determine reliably when a standard charge applies and when a listed charge may not, in fact, be the amount paid.** Because these provisions frequently operate at the contract level rather than the individual item level, the AMA recommends that CMS provide a structured means of indicating the scope at which a provision applies (e.g., item, service category, or contract) rather than forcing contract-level terms into item-level charge fields, where they would distort comparisons. The AMA likewise supports more structured reporting of payer, plan, product, network, and, where applicable, employer information; to minimize burden and improve interoperability, CMS should require the use of existing consensus data standards for applicable plans and the standard payer and provider identifiers already used in HIPAA electronic transactions, rather than obligating hospitals to create or maintain duplicative new identifiers. Consistent with the AMA's position that reporting obligations should fall on the entities that hold the relevant data, this reporting burden appropriately rests with hospitals and payers and should not be shifted onto physicians.

*The Consumer-Friendly Display*

For consumer-facing displays, the AMA recommends that CMS permit the use of consumer-friendly CPT descriptors that translate clinical terminology into plain language without changing the underlying meaning of the service. A plain language label should supplement, rather than replace, the standardized clinical code; the precise code and its version should remain available in the machine-readable record and accessible to consumers seeking additional information.

The RFI observes that the platforms and formats of price estimator tools vary widely, which makes it difficult for consumers to find and compare information, and it asks whether CMS should continue to deem hospitals compliant when they offer a price estimator tool. The AMA's overriding interest is comparability, but the AMA has previously recognized that patient-specific estimates, which a well-designed estimator tool can provide by reflecting the individual's benefit design and expected out-of-pocket costs, offer real value that a static file does not. Rather than eliminating estimator tools, CMS should ensure that the data underlying any consumer-friendly display are also published in a standardized, machine-readable, comparable format. Requiring hospitals that rely on an estimator tool to make the underlying data available in a separate standardized file would preserve the consumer value of personalization while restoring the cross-hospital comparability the current framework lacks.

Consistent with the goal of accuracy, CMS should require hospitals to generate their MRFs and consumer-facing displays from the same underlying structured price record, or to implement automated reconciliation between the two, so that differences in prices, service definitions, package contents, or discounted cash prices are flagged before publication. To support this, CMS should publish validation rules and test tools that identify invalid or obsolete codes, missing modifiers, standalone reporting of add-on codes, inconsistent packaging definitions, and discrepancies between the two required displays. This directly addresses the inconsistencies CMS has observed, which, left unexplained, undermine the accuracy on which the entire transparency framework depends.

*Quality and Administrative Burden*

As CMS advances the standardization of price data, the AMA reiterates two cautions from its prior OPPS comments. First, CMS should ensure that price information is not presented in a way that could mislead consumers about quality. As the AMA emphasized in its 2020 comments, cost information presented to consumers should be accompanied by appropriate safeguards against the assumption that a lower price signals lower quality, and any quality information displayed alongside price must be valid, reliable, and appropriate to the setting. In particular, physician-level measures were not designed for facility-level comparison and should not be repurposed for that use. As such, CMS should convene a Technical Expert Panel before publicly displaying quality measures in this context. Second, CMS should design any new standardization requirements to avoid imposing disproportionate burdens on smaller providers. The standardization requirements CMS ultimately adopts will fall unevenly across hospitals; small, rural, and independent facilities that lack dedicated data and information technology staff, and requirements calibrated only to the capabilities of large health systems could increase the very market consolidation that price transparency data are intended to discourage. **The AMA therefore recommends that CMS phase in any new requirements, provide clear technical guidance, and reuse data that hospitals already report wherever possible.**

Taken together, these recommendations would improve comparability while reducing the risk that consumers, employers, researchers, and application developers compare prices for services that appear similar but differ materially in scope or in their included components. They would also keep the focus on the comparison that matters most to patients: the total cost of a given service across the settings in which it may be furnished, with facility and professional charges clearly distinguished. The AMA supports meaningful, accurate, and comparable price transparency, and emphasizes that such transparency is a complement to, not a substitute for, structural reforms that address the underlying site-of-service payment differential. The AMA welcomes the opportunity to serve as a resource to CMS as it develops standardization requirements through future notice-and-comment rulemaking, including by contributing the coding and clinical expertise of the CPT Editorial Panel.

## I. ICRs for Expansion of Botulinum Toxin Injection Codes for Hospital Outpatient Department (OPD) Prior Authorization Process

The AMA strongly supports CMS' broader efforts to make any prior authorization that remains necessary electronic, interoperable, and substantially less burdensome. The AMA is developing and deploying SNOMED CT®-to-CPT® mappings specifically for prior authorization use cases and is providing the maps at no cost for such use. These mappings can connect clinician-documented SNOMED CT procedure concepts with the CPT codes required in administrative workflows, reducing manual translation, duplicate data entry, coding mismatches, and avoidable requests for additional information. The initiative aligns with FHIR®-based workflows, HL7® Da Vinci implementation approaches, and CMS' interoperability priorities. The AMA urges CMS to publicly endorse this standards-based approach and collaborate with the AMA, HL7, SNOMED International, Medicare Administrative Contractors, health systems, and technology developers to test and incorporate the mappings into Medicare prior authorization APIs and workflows. While better technology cannot cure an unwarranted prior authorization requirement, it can ensure that any requirements CMS retains are implemented in a real-time, consistent, and minimally burdensome manner.

### J. Cross-Program Proposals for Hospital Outpatient Quality Reporting Program (HOQRP) and Ambulatory Surgery Center Quality Reporting (ASCQ) Program.

**Recommendation:**

- The AMA supports removal of the *Follow-up from Normal Colonoscopy in Average Risk Patients* measure given that it was never intended to be used to measure the quality of care provided by a facility.

The AMA agrees that it is appropriate to remove this measure from the HOQRP and ASCQ programs as it was developed and tested to be used by individual clinicians and groups. We note that this measure addresses a known performance gap to ensure that patients receive screening and surveillance at appropriate intervals. As a prospective measure, over- and underutilization of colonoscopy is addressed before the patient undergoes their next colonoscopy. However, we do not support its use to evaluate the performance of hospital outpatient departments or ambulatory surgical centers.

### K. Hospital Outpatient Quality Reporting Program (HOQRP)

The AMA recognizes that CMS has not proposed any changes to the HOQRP program outside of the cross-program proposals but are reiterating our concerns that is it premature to move the *Emergency Care Access and Timeliness* electronic clinical quality measure (eCQM) from voluntary reporting in 2026 to mandatory reporting in 2027, as finalized in the 2026 OPPS-ASC Final Rule. The AMA appreciates CMS' attention to the emergency department boarding and overcrowding crisis that our nation is facing, by stewarding a measure that attempts to assist with the problem. However, we continue to remain concerned with the timeline to move to mandatory reporting due to the complexity of mapping the required data elements within EHR systems and the time needed to evaluate the validity of the resulting data once mapped.

The measure as finalized also requires modifications so that it places greater weight on the 4-hour boarding threshold and stratifies data by patient type to improve the accuracy and impact of the measure. For more specific feedback on the measure, please see the AMA's 2027 IPPS proposed rule comments.

### L. RFI: Advance Care Planning Electronic Clinical Quality Measure

The AMA supports the concept of the Advance Care Planning electronic clinical quality measure (eCQM) but recommends that CMS revise the measure specifications, build in flexibility for state requirements and religious or cultural exclusions, and complete additional testing across a wider range of EHRs and facility types before adoption in OPPS.

The AMA supports the inclusion of a measure on this important aspect of care but believes that the measure does not need to be applicable to all populations and procedures, and the denominator should be revised. For example, reviewing a patient's advance care planning prior to a cataract procedure may not be useful. It will be critical to ensure that there is sufficient flexibility in the type of documentation to ensure that facilities can be compliant with any state requirements or limitations. In addition, an exception or guidance allowing the documentation to account for those individuals for whom a discussion would be contrary to their religious and/or cultural beliefs must be incorporated. Also, validity of the individual data elements was only assessed in one EHR system, and reliability was evaluated in only 18 inpatient facilities, which is insufficient for a measure of this complexity and does not address the outpatient setting. Further testing is needed to ensure that these data can be collected across a wider range of EHRs and facilities of differing sizes and locations before inclusion in any program.

**M. RFI: Stratification of the All-Cause Transfer/Admission Measure**

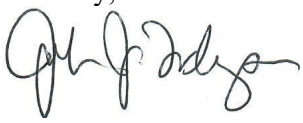
**Recommendation:**

- While the AMA has ongoing concerns with the use of measures examining the appropriateness of transfers and/or admissions to the hospital, we support the stratification of this measure.

We appreciate the consideration of the retrospective study demonstrating that the timing of a transfer or admission from an ophthalmology-specific ASC often occurs prior to the start of anesthesia. We believe that it serves as a good example that a broad measure without any detail on when the decision to transfer or admit was made could misrepresent the quality of care received by patients. Reporting the results by phase of care will yield data that are useful for quality improvement and for patient decision-making.

Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,



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