ALLIANCE of SAFETY-NET HOSPITALS

info@safetynetalliance.org
(703) 444-0989
safetynetalliance.org
4075 Wilson Blvd, Ste 840, Arlington, VA 22203

August 31, 2026

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

Subject: 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

Attention: File Code CMS-1850-P

Dear Administrator Oz:

I am writing on behalf of the Alliance of Safety-Net Hospitals to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed CY 2027 Medicare outpatient prospective payment system (OPPS) regulation that was published in the *Federal Register* on July 7, 2026.

The Alliance of Safety-Net Hospitals (ASH) is a nationwide coalition of safety-net hospitals that do not have dedicated sources of public funding. ASH members work together to advocate for Medicare, Medicaid, and other government health care policies that preserve access to care for hardworking families in the communities they serve and ensure safety-net hospitals have the public resources they need to continue serving those communities.

ASH would like to bring to your attention our views on the following aspects of the proposed regulation:

- Payment Update
- 340B Reimbursement
- 340B Remedy Offset
- Site Neutral Payment Policy
- National Provider Identifier Implementation

We address each of these areas of the rule in turn below.

Payment Update

CMS proposes a 2.4 percent update based on a projected 3.2 percent hospital market basket increase reduced by a 0.8 percentage point productivity adjustment. ASH appreciates that CMS recognizes the need for increased outpatient hospital payment in CY 2027 and we recognize the value within the proposal to maintain stability in the system with budget neutrality offsets stemming from the 340B payment changes. However, as explained more fully below, we encourage CMS to stay true to the purpose of the 340B

program by targeting funds to safety-net hospital providers rather than diluting the power of the program with general conversion factor increases.

Safety-net hospitals serve communities with significant Medicare, Medicaid, and uninsured populations; maintain essential outpatient access points; and support the clinical infrastructure needed to furnish primary, specialty, diagnostic, emergency, and other hospital-based outpatient care. While these providers consistently look for new financial efficiencies, those efforts cannot fully offset the significant increases in labor, drug, supply, technology, and compliance costs that have persisted since 2020, nor will they be able to offset the significant loss of savings associated with reductions to 340B reimbursements. Even with the proposed 2.4 percent payment update and additional conversion factor increases, ASH members still need the support of the current 340B reimbursement percentage to continue meeting the unique needs of their patients.

For hospitals with high Medicaid and uninsured patient volume, even modest payment reductions can have outsized consequences because these hospitals generally have less ability to offset government payment shortfalls through commercial payer revenue. As a result, losses that may appear modest in isolation can directly affect staffing, service line capacity, and the ability to maintain outpatient access in high-need communities. ASH urges CMS to consider the cumulative impact of the policies included in this proposed rule, including the proposed reductions related to 340B drug reimbursement, the accelerated 340B remedy offset, and site-neutral payment policy. Considered together with the modest positive payment update, these proposals materially reduce the resources available to safety-net hospitals to sustain outpatient access and invest in patient care infrastructure.

340B Reimbursement

CMS proposed a severe decrease in reimbursement to covered entities for 340B covered drugs, from average sales price (ASP) plus 6 percent to ASP minus 33.4 percent. This proposed payment amount is meant to reflect the hospital cost to acquire these drugs, but it is important to understand that the 340B program is not merely a cost-reimbursement mechanism. ASH is deeply concerned that finalizing the proposed reimbursement cut would fundamentally change the value of participation in the 340B program and weaken the ability for safety-net hospitals to continue to care for high volumes of Medicaid and uninsured patients – volumes which will certainly grow in the coming year.

Preserve 340B's Safety-Net Purpose

Congress created the 340B program to enable eligible providers to stretch limited resources so they can expand access to care for patients and communities that otherwise would not have reliable access to hospital or clinic services. ASH is concerned that CMS's proposal would substantially weaken that purpose by limiting reimbursement to drug acquisition cost. Without any margin for savings, there is little incentive for providers to participate in the program and commit to serving low-income patients who rely on them for medical care.

CMS estimates that the proposed policy would reduce beneficiary drug copayments by $1.15 billion in the first year. ASH certainly supports efforts to reduce financial burdens on beneficiaries, but CMS also estimates payments to covered hospitals will fall by more than $4 billion, a burden that many safety-net hospitals cannot shoulder. If this policy is finalized, CMS will effectively redirect essential resources away from the patients and communities the 340B program was intended to help.

Consider Impact on Enhanced Patient Services

Savings from the 340B payment margin empower safety-net providers to get creative to solve patient care problems. Our hospitals reinvest 340B savings into patient assistance funds, specialty pharmacy services, infusion access, enhanced care coordination, and other supports for patients who face clinical and financial barriers to care. ASH members cannot sustain these services with Medicare and Medicaid payment rates alone. For high-Medicaid hospitals, these reinvestments are central to sustaining access for patients who face the greatest barriers to care.

ASH urges CMS not to finalize the proposed ASP minus 33.4 percent payment policy for 340B-acquired drugs. A reimbursement policy focused only on cost coverage misses the point of the program, which is to support the ability of hospitals with constrained resources to meet the specific needs of their local communities and to provide a valuable tool to empower safety-net hospitals to solve difficult patient access problems.

340B Remedy Offset

ASH does not support CMS's proposal to accelerate the existing 340B remedy offset, which will take outpatient resources away from almost all hospitals, when they have budgeted for a much smaller offset for years. CMS previously finalized a plan to reduce the outpatient conversion factor by 0.5 percent each year for 16 years, and the agency now seeks to accelerate those reductions to 3 percent annually over a much shorter period. Since the 340B litigation concluded in 2023, hospitals have been planning for the 0.5 percent annual reduction. A sudden and significant acceleration of this reduction would be difficult for hospitals to absorb, especially for safety-net hospitals that have limited ability to offset payment reductions of this magnitude. If CMS believes a change to the repayment schedule is necessary, the agency should adopt a more gradual approach that avoids sudden financial disruption and accounts for broader industry pressures.

Safety-net hospitals rely heavily on government payer sources that often do not cover the full cost of care, leaving limited flexibility to offset reductions through other revenue sources. These providers are not in a position to absorb a significantly accelerated offset without evaluating cuts to services, delays in facility investments, or other operational changes that could affect patient access.

The acceleration of the repayments would also compound the effect of CMS's proposed 340B reimbursement reduction on the same hospitals. High-Medicaid safety-net hospitals would face overlapping reductions to outpatient payment and 340B-related resources at the same time they are managing perennial Medicaid shortfalls, growing uncompensated care stemming from recent and pending insurance coverage changes, and rising demand for outpatient services in the community. CMS should not finalize a compressed repayment schedule without accounting for this cumulative impact.

Site Neutral Payment Policy

CMS proposes to apply the physician fee schedule-equivalent payment rate to certain diagnostic imaging services without contrast when these services are furnished at excepted off-campus provider-based departments (PBDs). ASH opposes this proposal and urges CMS to exempt safety-net hospitals from this and all volume control site neutral payment policies if it is finalized.

Patients Rely on Hospitals for Primary Care

ASH members serve communities where many working families are uninsured, underinsured, or covered by Medicaid and depend on their local hospital for timely, practical access to primary and specialty care. In many of these communities, hospital outpatient departments fill gaps that exist because community physician practices are unavailable due to geography or other factors or unable to take on additional patients covered by government programs. Preserving appropriate payment for these safety-net provider-based sites helps keep care available in lower-cost outpatient settings and reduces the likelihood that patients will delay treatment until they need more expensive emergency or inpatient care. These hospitals are not maintaining outpatient sites to take advantage of payment differences; they are responding to clear community needs and helping ensure that patients have a reliable access point before their conditions become more serious and costly.

ASH urges CMS to consider the access implications of expanding site-neutral payment policy to diagnostic services provided at excepted off-campus departments.

Exempt Safety-Net Hospitals

If CMS finalizes this proposal and adds diagnostic services without contrast to the list of services that are subject to the volume control payment policy, we urge the agency to establish an exemption for safety-net hospitals, which will recognize the significant access needs of communities that rely on the health care safety-net. ASH believes a safety-net exemption can be developed carefully to give CMS authority to exempt providers with high public payer burdens that cannot sustain reductions in payment for Medicare and Medicaid services.

ASH supports the federal definition for safety-net hospital found in H.R. 7145 that could serve as means to protect these providers from site neutrality changes or other financial impacts that cannot easily be absorbed by such a hospital. Such a definition could use a combination of existing, readily available nationwide metrics to identify safety-net hospitals. By relying on multiple variables, it accounts for state-specific health care delivery structures and pinpoints relief to hospitals that provide the most care to low-income individuals relative to other hospitals within their own state.

Without the nuance that a safety-net exemption can provide, the proposed payment reduction would apply broadly to excepted off-campus PBDs without meaningfully addressing CMS's concerns about health system acquisition of physician practices. Congress specifically grandfathered certain off-campus provider-based locations from site-neutral payment reductions under Section 603 of the Bipartisan Budget Act of 2015. That statutory structure reflects Congress's recognition that existing outpatient care sites play an important role in their communities and should not be disrupted without careful consideration.

National Provider Identifier Implementation

CMS seeks feedback on implementing Section 6225 of the Consolidated Appropriations Act of 2026, which requires providers to obtain NPIs for their PBDs and submit attestations of compliance with provider-based regulations by January 1, 2028. ASH urges CMS to implement this mandate through a straightforward process that avoids payment disruption, inconsistent payer treatment, and unnecessary administrative burden.

Multiple Payers May Create Inconsistencies

ASH encourages CMS to work with MACs and Medicare Advantage plans to implement the NPI requirement in a way that will not disrupt the processing of otherwise valid claims. When a main hospital provider submits a claim for services performed at an outpatient PBD and places this secondary NPI on the claim, all payers must have consistent processes in place to accept that new NPI in their workflow. For these claims to process appropriately, every affected payer would need to recognize the secondary NPI, associate it correctly with the hospital and location, and update its claims-processing systems, enrollment records, edits, and validation checks to accept that relationship. If those updates are not completed consistently across Medicare, Medicaid, Medicare Advantage, and commercial payers, otherwise valid claims could be denied, delayed, or subject to additional manual review.

Administrative Burden Could Fall to CMS or MAC

The burden will extend beyond registering new NPIs. It is our understanding that hospitals need to enroll and maintain each PBD NPI across Medicaid, commercial, and Medicare Advantage payers; update access permissions; and manage additional account maintenance and claims inquiries. This added work would be especially difficult for safety-net hospitals with lean administrative workforce and multiple Medicaid and managed care relationships. This administrative work is also likely to impact the CMS and MAC workforce, through higher call volumes and requests for changes as hospitals seek appropriate access privileges for each NPI and keep personnel information updated so employees can check claims status and respond to additional requests for documentation.

Proposed Attestation Process

ASH supports CMS's proposal to allow providers to begin the attestation process up to two years before the January 1, 2028 deadline, as well as CMS's plans for a standardized form, centralized submission process, and five-year validity period for subsequent attestations. Compiling documentation for each PBD will still be significant, and ASH appreciates anything CMS and the MACs can do to streamline this documentation and minimize duplication.

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The Alliance of Safety-Net Hospitals appreciates the opportunity to comment on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director