AMERICAN OSTEOPATHIC ASSOCIATION

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September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1834-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency (CMS-1834-P)

Dear Administrator Oz:

The American Osteopathic Association (AOA), on behalf of the nearly 200,000 osteopathic physicians (DOs) and medical students we represent, appreciates this opportunity to comment on the CY 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule. The AOA shares CMS' goal of ensuring that patients receive high-quality, whole-person care in the most appropriate setting, and we appreciate the agency soliciting comment on ways to promote competition, establish appropriate payment across sites of care, and protect both beneficiaries and the Medicare system from unnecessary costs.

Osteopathic physicians are trained in patient-centered, whole-person approach to care, which entails partnering with patients to understand their backgrounds and health care needs. DOs practice in nearly every specialty, and across geographic settings and sites of care. DOs across the country serve in leadership roles for a broad range of academic programs, including medical schools, residency programs, and specialty boards, and we recognize the importance of the high standards set by accreditors and our institution in ensuring that patients across the country receive the best possible care. The high standards set by our institutions is what enables the U.S. to be a global leader in healthcare innovation and the delivery of high-quality care. With this in mind, we wish to express caution about the administration's intent to promote the formation and recognition of new accreditors for healthcare programs.

The AOA's comments in response to this proposed rule will focus on two key areas: (1) controlling unnecessary cost increases in the volume of outpatient services furnished in hospital outpatient departments (HOPDs), and (2) Graduate Medical Education Accreditation. Outlined below are the AOA's detailed comments in response to the relevant provisions.

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

The AOA strongly supports CMS' efforts to promote site-neutral payment to address incentives within Medicare payment systems that are encouraging service delivery in higher cost settings and catalyzing consolidation. In this rule, CMS is proposing to apply the Physician Fee Schedule equivalent payment rate for any HCPCS codes assigned to the drug administration ambulatory payment classifications (APCs) when provided at an off-campus PBD excepted from section 603 of the *Bipartisan Budget Act of 2015*. The agency also solicits input on whether this policy should be applied to on-campus HOPDs to better establish site-neutral payment across physician office and HOPD settings.

Consolidation of healthcare providers has intensified in recent years, through hospital acquisitions of physician practices, and mergers of hospitals and health systems. Between 2012 and 2024, the share of physicians working in a physician-owned practice declined from over 60% to 42%.[1] This shift has been driven by substantial payment differences created when hospitals receive payment for a service under both the physician fee schedule and relevant hospital prospective payment system. Because payment policy has created a financial incentive for hospitals to acquire practices, while making operating an independent practice exceptionally challenging under the physician fee schedule, physicians are increasingly choosing to become employed by hospitals and health systems due to the financial pressures and administrative burdens associated with maintaining independent practices.

This shift has a direct impact on patients. Consolidation has led to markets across the country becoming increasingly concentrated, or dominated by a limited number of enterprises. This reduced competition for healthcare services and greater market share by large hospitals and health systems is associated with greater out-of-pocket costs for patients and greater costs to federal programs, without any improvements in quality.[2] Consolidation has been associated with a 4.9% increase in Medicare enrollee spending, and a 14.1% increase in the price of services in the commercial market. In recognition of these trends, MedPAC recommended in its June 2023 report to Congress that CMS should adjust payment rates within the Hospital Outpatient Prospective Payment System (OPPS) to better align across sites of care.[3] **The AOA supports CMS taking these steps and urges CMS to (1) finalize these provisions as proposed to limit incentives to shift volume of drug administration services to off-campus PBDs, and (2) to more broadly address the financial incentives driving site of services shifts by applying this policy to HOPDs broadly. We also offer our assistance to CMS in identifying additional opportunities to establish site neutral payment, which will limit unnecessary spending within the Medicare program and reduce the incentive for hospitals to acquire physician practices**.

[1] American Medical Association. "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties." 2025. Available here.
[2] Rand Corporation. "Environmental Scan on Consolidation Trends and Impacts in Health Care Markets." 2022. Available here.
[3] Medicare Payment Advisory Commission. June 2023 Report to Congress. Available here.

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We wish to use this opportunity to highlight comments the AOA is making in response to proposed policies for the CY 2026 physician fee schedule, which CMS claims seek to achieve a similar goal. In the MPFS proposed rule, CMS is proposing to reduce the portion of the facility PE relative value units (RVUs) allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. CMS suggests that overpayment for services in the facility setting rendered by employed physicians is creating incentives for acquisitions of practices and site of service shifts. While the AOA agrees that differences in payment across settings is driving acquisitions, we strongly disagree with CMS that reducing payment under the PFS will contribute to solving this challenge. We urge the agency to focus on establishing site-neutral payments through changes within the OPPS.

Care provided by physicians in facility settings already receive a reduced payment rate, relative to non-facility rates, to account for differences in overhead costs between sites of care. While it is true that a growing share of physicians are employed, these shifts are not driven by payment differentials within the physician fee schedule, but rather by substantial payment differences created when hospitals receive payment for a service under both the physician fee schedule and relevant hospital prospective payment system. While the share of physicians working in private practices now sits at 42%, this indicates that a substantial share of physicians still maintain practice overhead even though they may render services in a facility setting. The share of physicians in private practice is higher for specialties that commonly provide services in the hospital setting, including obstetrics/gynecology (46%), orthopedic surgery (54%), ophthalmology (70%), and other surgical subspecialties (51%).[4] A reduction to indirect PE RVUs for services in the facility setting will only catalyze consolidation of providers, forcing many physicians to close their practices or choose to become employed physicians**. For this reason, we urge CMS to focus efforts to establish site-neutral payment on the payments captured under the OPPS**, thus reducing inappropriate payments to hospitals while protecting physicians who maintain independent practices.

Request for Information: Adjusting Payment Under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings

Should we limit OPPS payment for certain services to the payment made for that service under the ASC payment system or the PFS—depending on the setting where the service is performed most frequently? If we were to adjust payment based on the setting-specific volume of ambulatory services, should we pay the ASC payment amount if the service is predominantly performed in the ASC setting; and if the service is predominantly performed in the physician office setting, should we continue to calculate the PFS-equivalent rate using a PFS relativity adjuster that we would periodically update?

[4] American Medical Association. "Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties." 2025. Available here.

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We believe it is appropriate to establish payment rates based on where a service would most typically be performed, and support establishing rates based on this site of service data. It is important to note that many procedures can be rendered in both the HOPD and ASC setting, but reimbursements are substantially lower in the ASC setting. We believe that efforts to promote site neutrality should seek to encourage the delivery of services in the site of care that is most appropriate, and should therefore support delivery of services in ASCs as opposed to HOPDs. ASCs are often community-based sites of care, making them more accessible for patients, and their lower payment rates also entail lower cost sharing for patients.

In determining the setting in which a service is performed most frequently, should we use the most recent data available or should we use data that is 5 or even 10 years prior to the rate-setting year?

The AOA encourages CMS to use data over a window of time for rate-setting, instead of data from the most recent year in which it is available. A broad range of factors can disrupt care patterns and influence where services are delivered, as we experienced during the COVID-19 pandemic, and we believe that relying on a broader window would prevent disruptions within a single year from steering policy.

Graduate Medical Education Accreditation

CMS is proposing policy in alignment with President Trump's executive orders on "Ending Illegal Discrimination and Restoring Merit-based Opportunity" and "Reforming Accreditation to Strengthen Higher Education". Provisions in the proposed rule seek to prohibit unlawful discrimination by accreditors and academic programs receiving Medicare funding. CMS expresses its intent to improve "the potential for competition in the accreditation space" stating that the "Secretary may recognize other organizations that meet or exceed Medicare's requirements as accreditors to increase the potential for competition in the accreditation space and improve the quality of the accreditation process." The AOA collaborates closely with our partners across the spectrum of medical education, including the Commission on Osteopathic College Accreditation, which accredits colleges of osteopathic medicine, and the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency programs. The AOA also oversees osteopathic specialty board certification for physicians across the country. We are committed to maintaining and promoting exceptionally high standards across all our programs and working with partners to this end.

We wish to express concern with CMS' intent to promote competition in the accreditation space, as it is essential that CMS prioritize academic standards to ensure that US-based programs remain a "gold standard" for medical education globally. We are concerned that entry of new accreditors, with limited experience and limited relationships with high quality institutions for training new physicians, may jeopardize patient care by diminishing the quality of residency training. We urge CMS to place patients at the center of any action related to accreditation to ensure that trainees

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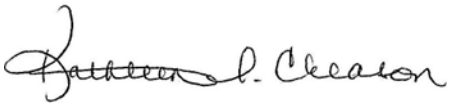
receive the appropriate knowledge, clinical training, and skill development, under appropriate supervision, so they can deliver the highest possible standard of care.

Conclusion

The AOA appreciates the opportunity to comment on the CY 2026 OPPS and ASC Proposed Rule. We look forward to continuing to work with CMS on developing final regulations. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, Vice President, Public Policy at jvillarama@osteopathic.org .

Sincerely,

Robert G.G. Piccinini, DO, D.FACN
President, AOA



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