August 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1850-P, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; CY 2027 - 340B Drug Payment Policy and 340B Remedy Offset

Dear Administrator Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and the hospitals and health systems we represent across Arizona, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System proposed rule, CMS-1850-P.[1]

AzHHA represents a diverse hospital community that includes nonprofit, investor-owned, and governmental hospitals; major teaching and safety-net institutions; and rural hospitals serving communities across a large, geographically dispersed state. Those differences are especially important in evaluating CMS' proposals to reduce payment for most 340B-acquired drugs from ASP plus 6% to ASP minus 33.4%, and to increase the annual 340B remedy reduction to the OPPS conversion factor from 0.5% to 3%. CMS estimates that the new 340B payment policy would reduce OPPS drug payments by approximately $4.85 billion in CY 2027 and redistribute an equal amount through an 8.44% increase in non-drug OPPS payment rates.[2]

Our review of CMS' Arizona-specific impact data underscores that no single hospital is affected equally by these proposals. Some Arizona hospitals benefit significantly under CMS' model, while others experience substantial reductions. AzHHA believes our comments should recognize both realities.

Accordingly, AzHHA urges CMS to:

- Maintain the existing 0.5% annual 340B remedy offset rather than accelerate it to 3%.
- Not finalize ASP minus 33.4% on the current record without providing additional drug-level and provider-level information sufficient for stakeholders to independently evaluate the methodology.
- If CMS determines that it must implement an acquisition-cost-based policy in CY 2027, adopt a more conservative or transitional approach, including consideration of CMS' own ASP minus 28% alternative, while additional data are evaluated.
- Preserve the proposed exemptions for rural Sole Community Hospitals (SCHs), children's hospitals and PPS-exempt cancer hospitals.
- Ensure that any 340B payment policy remains fully budget neutral each year, with the redistribution recalculated using actual claims experience.
- Closely monitor and, where appropriate, provide transition protections for hospitals experiencing disproportionate reductions, particularly high-DSH, teaching and other safety-net hospitals.

Arizona's Experience Demonstrates Both the Benefits and the Risks of CMS' Proposal

AzHHA appreciates an important feature of CMS' proposal: the reduction in 340B drug reimbursement is designed to be budget neutral within OPPS. CMS proposes to redistribute the estimated $4.85 billion reduction through an 8.44% increase in payment for non-drug OPPS services furnished by hospitals. CMS also recognizes that the resulting effect will differ significantly among hospitals depending on whether they participate in 340B and the relationship between their 340B drug volume and non-drug outpatient services.[3]

CMS describes that dynamic directly in its impact analysis. For non-340B hospitals and hospitals exempt from the proposed drug reduction, CMS generally expects higher payments because those providers receive the non-drug budget-neutrality increase without a corresponding reduction in drug reimbursement. For 340B hospitals, CMS states that the effect depends on the volume of 340B drugs furnished relative to non-drug services and that, for most 340B providers, reduced drug payments will outweigh increased non-drug payments.[4]

Arizona's facility-specific data illustrate this redistribution particularly clearly. AzHHA analyzed the 57 Arizona acute-care hospitals identified in CMS' CY 2027 NPRM OPPS Hospital Impact File. Under CMS' overall proposed-rule model:

- 48 of 57 Arizona acute-care hospitals have a positive overall impact;
- Arizona hospitals collectively experience an estimated $16.8 million increase, or 1.17%;
- all 22 proprietary hospitals in the Arizona file have positive modeled impacts, collectively gaining approximately $15.9 million, or 5.76%;
- the 34 voluntary/nonprofit hospitals are essentially flat in aggregate, gaining approximately $0.9 million, or 0.08%, with 25 experiencing positive impacts and nine experiencing negative impacts;
- all seven Arizona hospitals identified by CMS as rural SCH/EACH hospitals have positive impacts, collectively gaining approximately $10.85 million, or 4.65%;
- the 14 Arizona hospitals with DSH patient percentages above 35% collectively experience an estimated $13.43 million reduction, or 3.46%; and
- Arizona's nine major teaching hospitals collectively experience an estimated $7.28 million reduction, or 1.67%.

These figures are AzHHA calculations using CMS' facility-specific impact file and reflect each hospital's overall modeled OPPS impact under the proposed rule - not a hospital-specific estimate attributable exclusively to the new 340B policy.[5]

These findings are consistent with the national distributional effects CMS describes in Table 88. CMS estimates that the proposed 340B policy itself would produce a 5.7% increase for rural SCHs because they would be exempt from the direct drug payment reduction while receiving the 8.44% non-drug increase. CMS also estimates substantially different overall effects by ownership and teaching status.[6]

AzHHA believes these benefits are important and should be acknowledged. In particular, payment improvements to Arizona's rural SCHs are significant at a time when rural providers face extraordinary financial and workforce challenges. At the same time, a positive statewide aggregate does not mean that the proposal is benign for every hospital or community. Arizona's data demonstrate that losses are concentrated among some hospitals serving disproportionate shares of low-income and medically complex patients and among major teaching institutions. We therefore urge CMS to evaluate the distribution of payment changes, not merely the aggregate amount or the number of hospitals receiving increases.

AzHHA Supports the Goal of Using Reliable Acquisition-Cost Data, but the Record Does Not Yet Establish That ASP Minus 33.4% Is the Appropriate Rate

AzHHA does not object to the principle that Medicare should consider reliable acquisition-cost information when establishing payments for separately payable drugs. Nor do we dismiss CMS' concern that Medicare payment and beneficiary cost sharing may substantially exceed a hospital's acquisition cost for some 340B drugs. The policy question, however, is not simply whether 340B acquisition costs are generally lower than ASP plus 6%. The question is whether the available evidence is sufficiently complete, representative and transparent to support ASP minus 33.4% as the payment rate for all affected 340B-acquired drugs beginning January 1, 2027.

On that question, AzHHA believes additional transparency and analysis are warranted. After CMS refined the survey population, only 28.6% of 340B hospitals reported acquisition-cost data, compared with 53.3% of non-340B hospitals. CMS also reports that survey respondents were somewhat more likely to have lower claims billing volume, be smaller, be rural, and not be major teaching hospitals. CMS applied inverse probability weighting and concluded that the resulting estimates were sufficiently representative and statistically reliable.[7]

Those findings support CMS' methodology, but they do not eliminate reasonable concerns about generalizability. In its August 26 comments on CMS-1850-P, the American Hospital Association (AHA) points to the relatively low 340B response rate, the underrepresentation of higher-drug-volume hospitals, and the limits of inverse probability weighting when factors associated with both nonresponse and acquisition cost are not observed. AHA also identifies information that CMS has not publicly provided, including drug-level response counts, drug-specific acquisition-cost estimates and statistical measures, and details sufficient to independently evaluate the weighting model and NDC-to-HCPCS crosswalk.[8]

AHA additionally raises an important statutory question. Section 1833(t)(14)(D)(iii) of the Social Security Act refers to surveys that have a large sample of hospitals sufficient to generate a statistically significant estimate of average hospital acquisition cost for "each specified covered outpatient drug." CMS, by contrast, proposes applying a single discount factor to drug-specific ASP amounts rather than calculating individual acquisition-cost amounts for each 340B drug. The Supreme Court has previously described the acquisition-cost survey as an "important procedural prerequisite" before HHS may vary reimbursement rates by hospital group.[9]

AzHHA does not take a position in this letter on whether AHA's statutory interpretation ultimately would prevail in litigation. We believe the issue is sufficiently consequential that CMS should clearly explain in the final rule how the aggregate discount methodology satisfies the statute's drug-specific survey requirements and release sufficient de-identified data to permit meaningful independent review.

The survey's data-refinement methodology also merits additional transparency. CMS reports that it removed 14,313 of 160,430 survey records through five refinements before its final analysis. AHA argues that several exclusions and data-cleaning choices could affect the resulting acquisition-cost estimate and asks CMS to release underlying drug-level information so stakeholders can evaluate the effect of those methodological decisions.[10]

CMS' Own Alternative Supports a More Cautious Approach

Importantly, the proposed rule itself demonstrates that 33.4% is not the only acquisition-cost measure CMS considered. CMS calculated an alternative 340B acquisition-cost margin of ASP minus 28% using HRSA ceiling-price data and OPPS claims utilization and expressly solicits comment on paying 340B-acquired drugs at ASP minus 28%. CMS estimates that this alternative would reduce 340B drug

payments by approximately $4.68 billion and produce an 8.14% budget-neutral increase in non-drug OPPS payments.[11]

If CMS concludes that it must implement an acquisition-cost-based payment methodology beginning in CY 2027, AzHHA urges the agency to consider ASP minus 28% as an interim or transitional methodology, or otherwise phase in the reduction, while CMS provides the additional drug-level information described above and evaluates actual claims experience. Such an approach would recognize CMS' legitimate interest in better aligning payment with acquisition cost without immediately adopting the largest reduction supported by an aggregate survey whose 340B response rate and drug-level representativeness remain contested.

We also urge CMS to preserve its proposed exemptions for rural SCHs, PPS-exempt cancer hospitals and children's hospitals. Arizona's experience demonstrates the importance of that protection: every rural SCH/EACH hospital included in CMS' Arizona acute-care impact file is projected to experience an overall payment increase.[12]

Any Final Policy Must Remain Fully Budget Neutral

If CMS implements a 340B payment adjustment, AzHHA strongly supports maintaining full budget neutrality. The budget-neutral redistribution is the reason many Arizona hospitals - including rural SCHs and non-340B hospitals - benefit from the proposed policy. CMS itself notes that the 8.44% adjustment could change in the final rule because of updated data, modifications to the estimate methodology, or other factors.

AHA raises a particularly important implementation lesson from the 2018-2022 policy. It argues that CMS did not annually recalculate the prior budget-neutrality adjustment as actual drug and non-drug utilization changed and recommends that, if CMS moves forward with a new policy, the agency recalculate the budget-neutrality adjustment annually using actual OPPS claims data. AzHHA supports that recommendation. CMS should not establish an adjustment for CY 2027 and allow it to remain static if actual utilization diverges from the assumptions used to set the rate.[13]

CMS Should Not Accelerate the 340B Remedy Offset to 3%

AzHHA separately opposes CMS' proposal to increase the existing 340B remedy offset from 0.5% to 3% in CY 2027. These policies should not be conflated. The new ASP minus 33.4% proposal addresses prospective payment for 340B-acquired drugs beginning in CY 2027. The remedy offset addresses CMS' effort to recover prior non-drug OPPS payments associated with the 2018-2022 340B payment policy.[14]

AHA appropriately notes that when CMS originally established the 0.5% remedy adjustment, the agency expressly considered the need to account for reliance interests and avoid imposing an excessive immediate burden on affected hospitals. CMS now proposes a sixfold increase in the annual offset. AHA argues that CMS has not adequately explained why the burden on impacted entities should receive substantially less weight in the new timetable. AzHHA shares that concern.[15]

The accelerated remedy offset is especially difficult to justify when layered on top of a new 340B payment methodology and other federal payment and coverage changes that hospitals will absorb over the next several years. It also reduces payments to hospitals that may otherwise benefit from the new 340B redistribution, thereby undercutting part of the very gains cited by supporters of the new policy. AzHHA urges CMS to maintain the existing 0.5% annual remedy adjustment for CY 2027.

CMS Should Monitor Concentrated Effects on Safety-Net and Teaching Hospitals

If CMS implements a new acquisition-cost payment methodology, AzHHA urges the agency to establish a transparent process for monitoring its effects on hospitals whose losses are disproportionately large relative to outpatient Medicare revenue, DSH burden or role as regional safety-net providers. Arizona provides a compelling reason to do so. Although CMS' overall modeling shows a net positive impact for Arizona hospitals, hospitals with DSH percentages above 35% collectively lose about $13.4 million, while major teaching hospitals collectively lose about $7.3 million.

A national or statewide finding that "most hospitals benefit" does not fully describe the access implications if losses are concentrated among a smaller number of institutions that care for disproportionate shares of low-income, medically complex, or otherwise vulnerable patients. If CMS proceeds, we encourage it to monitor those effects and consider appropriate transition protections where payment reductions are unusually large or threaten access to essential services.

Conclusion

Arizona demonstrates why the CY 2027 340B proposal cannot fairly be characterized as uniformly beneficial or uniformly harmful. Many Arizona hospitals benefit under CMS' model. The gains to investor-owned hospitals and rural SCHs are meaningful, and AzHHA does not ask CMS to disregard them.

At the same time, those gains arise from a significant redistribution of Medicare outpatient payments, and losses are concentrated among certain nonprofit, high-DSH and teaching hospitals. Questions also remain about whether the acquisition-cost survey provides a sufficiently transparent and drug-specific basis for establishing ASP minus 33.4% as an ongoing national payment methodology.

AzHHA therefore urges CMS to take a measured approach: retain the 0.5% remedy offset; provide additional information sufficient to independently evaluate the acquisition-cost methodology; refrain from finalizing ASP minus 33.4% until those issues are addressed; and, if CMS nevertheless implements a policy in CY 2027, use a more conservative or transitional methodology, preserve the rural SCH and other exemptions, ensure full annual budget neutrality, and monitor the policy's effects on safety-net and teaching hospitals.

Thank you for your consideration of these comments. We look forward to continuing to work with CMS to ensure that Medicare payment policies support access to high-quality hospital care for patients and communities throughout Arizona.

Sincerely,

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References

1. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, 91 Fed. Reg. 41,734 (July 7, 2026) (CMS-1850-P).

2. 91 Fed. Reg. at 41,872-73, 41,895-96 (3% remedy-offset proposal; ASP minus 33.4% proposal; $4.85 billion / 8.44% budget-neutral redistribution).

3. Id. at 41,895-96.

4. Id. at 42,013-14 (Table 88 discussion of 340B redistribution and hospital-specific effects by 340B status/service mix).

5. CMS, 2027 NPRM OPPS Hospital Impact File (June 29, 2026), AzHHA analysis of Arizona acute-care hospitals (CCNs 030xxx).

6. 91 Fed. Reg. at 42,013-14 (Table 88; 5.7% 340B-policy effect for rural SCHs).

7. Id. at 41,880-87 (survey response rates, respondent characteristics, inverse probability weighting and statistical-validity analysis).

8. American Hospital Association, Comments on CMS-1850-P Regarding 340B Payment Proposals (Aug. 26, 2026), at 12-18, 25-26.

9. 42 U.S.C. § 1395l(t)(14)(D)(iii); American Hospital Association v. Becerra, 596 U.S. 724, 735 (2022); AHA Comments on CMS-1850-P, at 10-14, 22-23; 91 Fed. Reg. at 41,889.

10. 91 Fed. Reg. at 41,879-80; AHA Comments on CMS-1850-P, at 19-26.

11. 91 Fed. Reg. at 41,889, 41,895-96 (ASP minus 28% alternative; approximately $4.68 billion / 8.14% redistribution).

12. Id. at 41,891-92 (proposed exemptions for rural SCHs, children's hospitals and PPS-exempt cancer hospitals).

13. AHA Comments on CMS-1850-P, at 30-31 (recommendation to recalculate budget neutrality annually using actual OPPS claims).

14. 91 Fed. Reg. at 41,872-73 (proposal to increase the annual remedy reduction from 0.5% to 3%).

15. AHA Comments on CMS-1850-P, at 3-4; Medicare Program: Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for CYs 2018-2022, 88 Fed. Reg. 77,150, 77,179 (Nov. 8, 2023).

Source links: CMS-1850-P - https://www.federalregister.gov/d/2026-13656 | CMS rule downloads - https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1850-p