American College of Radiology™

August 28, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-1850
Electronically submitted

Dear Administrator Dr. Oz:

The American College of Radiology (ACR), a professional medical specialty society representing over 41,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine as well as medical physicists appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services' (CMS) calendar year (CY) 2027 proposed rule on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comments on the following important issues:

1. Proposed APC Placement of Established CPT/HCPCS Codes
2. Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services
3. HOPPS Payment for Software as a Medical Service (SaMS)
4. Payment Policy for Diagnostic Radiopharmaceuticals
5. Prospective Adjustment to Payments for Non-Drug Items and Services (340B Remedy Offset)
6. Hospital Outpatient Quality Reporting (OQR) Program Updates

Proposed APC Placement of Established CPT/HCPCS Codes

CT Colonography Services

In the CY2025 HOPPS final rule, CMS added coverage for computed tomography colonography (CTC) services, assigning a Status Indicator of S to CPT code 74263 to indicate separate payment. In this proposed rule, CMS proposes to place 74263 in APC 5523 (Level 3 Imaging without Contrast) with payment rate $271.13 for CY 2027.

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

CPT Code	Long Descriptor	ACR Proposed	ACR Proposed	CY 2027 Proposed	CY 2027 Proposed
74263	Computed tomographic (CT) colonography (i.e., virtual colonoscopy), screening, including	5524 – Level 4 Imaging without Contrast	$622.55	5523 – Level 3 Imaging without Contrast	$271.13

ACR Perspective and Comments

The ACR appreciates CMS' efforts to improve access to colorectal cancer screening services for Medicare beneficiaries and continues to support appropriate reimbursement for screening CT colonography (CTC). The addition of Medicare coverage is an important step toward expanding screening options. Nonetheless, reimbursement for CTC remains substantially lower than payment for comparable CT imaging services, and ACR is concerned that the proposed payment methodology may not adequately reflect the resources required to furnish CT colonography services. Unlike many imaging services assigned to non-contrast imaging APCs, CTC requires a bowel preparation regimen, oral contrast administration, disposable insufflation tubing, automated CO_2 insufflation equipment and supplies, multiple scan acquisitions, and significant technologist involvement, with radiologist oversight often necessary to ensure study quality. These additional clinical and operational resources support assignment to APC 5524 (Level 4 Imaging Without Contrast) for both screening and diagnostic CTC services.

To better align payment with the complexity and resource costs associated with CTC, the ACR recommends that CMS reassign CPT code 74263 from APC 5523 (Level 3 Imaging without Contrast) to APC 5524 (Level 4 Imaging without Contrast). Payment under APC 5524 would more appropriately reflect reimbursement levels established for comparable CT abdomen and pelvis imaging services and help ensure providers can sustainably offer this important screening exam.

The current payment rate may discourage hospitals and imaging practices from offering or billing for CTC, limiting beneficiary access and suppressing utilization. Lower utilization subsequently results in less representative claims data for future APC recalibration, creating a cycle in which payment rates continue to underestimate the resources required to furnish the service. Assigning CTC to a higher APC would support broader adoption, generate more representative utilization data, and help ensure future payment rates more accurately reflect the costs of providing this clinically valuable colorectal cancer screening service.

Site-Neutral Considerations

As CMS considers volume-control payment policies and potential PFS-equivalent payment methodologies, we urge the agency to account for service-specific resource differences

and avoid treating all non-contrast imaging services as comparable in complexity or cost. We further encourage CMS to consider exceptions, safeguards, or transition policies for preventive screening services such as CTC, which plays an important role in colorectal cancer screening and population health initiatives. This will ensure that payment changes do not inadvertently reduce beneficiary access or discourage adherence to recommended screening guidelines.

Radiation Oncology Treatment Delivery

Beginning with calendar year 2026, CPT codes 77402, 77407 and 77412 were significantly revised. For CY 2027, CMS proposes to assign CPT code 77407 to APC 5622 (Level 2 Radiation Therapy) with proposed payment rate of $460.55.

CPT Code	Short Descriptor	CY2027 Proposed APC	CY2027 Proposed Payment	ACR Proposed APC	ACR Proposed Payment
77407	Radiation tx delivery lvl 2	5622 – Level 2 Radiation Therapy	$460.55	5623 - Level 3 Radiation Therapy	$640.75

ACR Perspective and Comments

The ACR recognizes the challenges associated with assigning APCs when CPT codes are substantially revised to describe different services. Under the revised code family, technique alone does not determine code selection. Instead, code selection is based on complexity and specific patient and clinical characteristics. The complexity of IMRT varies depending on the treatment area, number of targets, differential doses delivered, and technique used.

We also remain concerned that the proposed APC assignment for CPT code 77407 relies on historical claims data that do not accurately reflect the resources associated with the revised code. Because the descriptor and underlying services have changed significantly, the available claims data largely represent services furnished under the previous coding construct and may not capture the current clinical complexity, staff time, equipment utilization, supplies, and operational resources required to provide the service today. As a result, the geometric mean cost derived from these legacy claims likely understates the actual costs of furnishing the revised service.

Accordingly, the ACR supports assigning CPT code 77407 to APC 5623. The deleted IMRT treatment delivery codes, 77385 and 77386, are more closely aligned with the resources and clinical complexity now reflected in the revised treatment delivery code family than the historical data associated with the former 77407 descriptor. Moreover, prior to the 2026 coding revisions, both 77385 and 77386 were assigned to APC 5623 (Level 3 Radiation

Therapy), providing a strong precedent to support the assignment of 77407 to the same APC.

For these reasons, the ACR recommends that CMS reassign CPT code 77407 to APC 5623 (Level 3 Radiation Therapy), with a payment rate of $640.75. This reassignment would more appropriately reflect the clinical complexity and resource intensity associated with the revised code while addressing the significant payment gap created by the proposed APC placement. In addition, assigning 77407 to APC 5623 would help maintain Medicare beneficiary access to these important radiation oncology treatment services during the transition period while CMS collects more representative claims data under the revised coding structure.

Regarding the APC categories covering the radiation therapy treatment delivery codes, ACR has been informed by our colleagues in the American Society for Radiation Oncology (ASTRO) & the American College of Radiation Oncology (ACRO) that if payments rates remain unadjusted into CY 2027, ongoing reimbursement instability seriously threatens patient access and quality of care across the country. ACR urges CMS to consider both the crosswalk recalibrations proposed by ACRO and/or the payment remedies advanced by ASTRO to ensure final CY 2027 HOPPS and MPFS rates protect essential cancer care infrastructure and patient access.

Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services

CMS proposes to use the agency's authority under section 1833(t)(2)(F) of the Social Security Act to apply the Physician Fee Schedule (PFS)-equivalent payment rate for any HCPCS codes assigned to the imaging without contrast ambulatory payment classifications (APCs) when provided at an off-campus provider based department (PBD) excepted from section 603 of the Bipartisan Budget Act of 2015. As with the existing volume control method for off-campus clinic visits and drug administration services, CMS proposes to exempt rural Sole Community Hospitals from this proposed policy.

CMS believes that paying for imaging without contrast services provided at excepted off-campus PBDs at the PFS-equivalent rate could be an effective method to control the volume of what the agency asserts are unnecessary services. CMS states that this method will control unnecessary volume increases both in terms of the number of covered OPD services furnished and the costs associated with those services. In addition to the payment proposal, CMS solicits public comments on other ways it should exercise the Secretary's statutory authority under section 1833(t)(2)(F) of the Act.

ACR Perspective and Comments

The ACR appreciates CMS's efforts to ensure that Medicare beneficiaries receive appropriate, high-quality care and recognizes the agency's statutory authority under section 1833(t)(2)(F) of the Social Security Act to develop methods for controlling

unnecessary increases in the volume of covered outpatient department services. However, we do not believe CMS has demonstrated that the payment differential between hospital outpatient departments and physician offices is the primary driver of imaging utilization growth, nor has CMS established that the services targeted by this proposal represent unnecessary volume warranting intervention.

CMS suggests that payment differences may influence site-of-service decisions and contribute to increased utilization. However, the proposed rule does not adequately distinguish between growth resulting from inappropriate utilization and growth attributable to evolving patient needs, demographic trends, expanding clinical indications, improved access to diagnostic services, or shifts in care delivery patterns. Before implementing a non-budget-neutral payment reduction for selected imaging services, CMS should provide stronger evidence demonstrating that payment policy, rather than these other factors, is responsible for the utilization trends the agency seeks to address.

Furthermore, available data suggest that imaging growth in non-excepted off-campus provider-based departments, which are already reimbursed under site-neutral payment policies, has exceeded growth in excepted off-campus departments. This observation raises important questions regarding CMS's underlying assumption that higher OPPS payment rates are driving excessive utilization. If similar or greater growth is occurring in settings already subject to site-neutral payment, the relationship between payment differentials and imaging volume may be significantly more complex than assumed in the proposed rule.

More broadly, ACR is concerned that the proposal selectively targets certain APCs and cost centers without adequately considering the analytical framework underlying the OPPS itself. The ambulatory payment classification system is built upon claims-based geometric mean costs designed to reflect the relative resources required to furnish services. By using a separate payment methodology to reduce reimbursement for selected APCs based on concerns about utilization rather than resource consumption, CMS risks undermining the integrity of the APC structure and creating payment policies that are increasingly disconnected from the cost-based principles on which the OPPS was established. Absent evidence of fraud, abuse, or extreme site-of-service steering, ACR believes payment policy should continue to be grounded in the established APC methodology rather than selectively overriding APC payment rates for particular service categories.

The ACR is concerned that several preventive imaging services (*i.e.* CT colonography, lung cancer screening, abdominal aortic aneurysm (AAA) screenings, and DXA scans) are assigned to the imaging without contrast APCs targeted by this proposal. As a result, application of the Physician Fee Schedule (PFS)-equivalent payment rate to these services could have unintended consequences for beneficiary access to recommended screening examinations. Reductions in payment for these services may affect provider capacity and

availability, creating potential barriers to access that could discourage beneficiary participation and adherence to recommended screening schedules. CMS should carefully evaluate the impact of this proposal on preventive imaging services and consider whether additional safeguards are necessary to ensure continued access to these important imaging screening examinations.

The ACR supports CMS's proposal to exempt rural Sole Community Hospitals (SCHs) from the imaging without contrast volume-control methodology. However, many rural hospitals that are not SCHs face the same access and financial challenges and rely on off-campus provider-based departments to provide important imaging services in their communities. The ACR encourages CMS to extend the exemption to all rural hospitals, including rural non-SCH hospitals, to help maintain access to imaging services for Medicare beneficiaries in rural areas.

If CMS finalizes this policy, the ACR recommends establishing a payment floor to ensure that the PFS-equivalent amount under the OPPS does not fall below the corresponding PFS technical component payment rate. Establishing this floor would mitigate the risk of excessive payment reductions that are disconnected from the costs of furnishing imaging services and would help preserve beneficiary access while CMS evaluates the long-term effects of the policy.

The ACR urges CMS to apply any savings generated by this policy in a budget-neutral manner by redistributing them within the OPPS. Reinvesting these funds in outpatient hospital services would help maintain beneficiary access to care and support essential imaging and screening services while mitigating potential adverse effects on hospitals.

In addition, CMS has previously acknowledged that charge compression can distort OPPS payment rates by obscuring meaningful differences in resource utilization across services. If the agency is concerned that certain imaging APCs have reimbursement levels that are lower than appropriate or that payment disparities between settings are being driven by limitations in OPPS rate setting, addressing charge compression would represent a more methodologically sound solution.

Charge Compression:
ACR is concerned that CMS is responding to perceived payment disparities between the OPPS and PFS by further reducing OPPS payments rather than addressing longstanding flaws in the OPPS rate-setting methodology. CMS has previously acknowledged concerns regarding charge compression and the accuracy of CT and MRI cost reporting. The extremely low cost-to-charge ratios (CCRs) reported for these cost centers suggest that hospital costs may be systematically understated, resulting in APC payment rates that already undercompensate hospitals for the resources required to furnish advanced imaging services.

Public comments and CMS's own rulemaking history have raised concerns that hospitals may not consistently allocate high-cost imaging equipment and related capital expenses to CT and MRI cost centers. This practice can lead to distorted CCRs and inaccurate payment rates. As a result, current OPPS imaging payments may not accurately reflect hospital costs.

If CMS is concerned that certain imaging APC payments are lower than corresponding PFS payment rates, the appropriate response is to address the underlying charge compression and cost-reporting issues that affect OPPS rate setting. Before finalizing this proposal, CMS should evaluate whether current imaging APC rates accurately reflect hospital resource costs and consider reforms to improve cost reporting and payment accuracy.

Appropriate Use Criteria (AUC):
While ACR does not support the proposed site neutral payment policy, we recognize and share CMS's broader goal of reducing unnecessary imaging and ensuring Medicare beneficiaries receive the right test at the right time. In fact, Congress has already provided CMS with a proven statutory tool specifically designed to address unnecessary advanced imaging utilization through physician-led clinical decision support and Appropriate Use Criteria (AUC).

As stated in the proposed rule, CMS has the authority under Section 1833 (t)(2)(f) of the Social Security Act to "develop a method for controlling unnecessary increases in the volume of covered OPD services". ACR shares CMS's concern about the volume of potentially unnecessary imaging services and believes CMS should exercise its authority to modernize and implement a physician-led, technology-forward imaging utilization management tool that was enacted under the Protecting Access to Medicare Act of 2014 (PAMA) but was never fully implemented.

ACR has long been a proponent of optimizing patient care to ensure patients get the right imaging at the right time - even if that means no imaging is needed. To that end, we supported section 218 of PAMA which requires ordering clinicians to consult AUC, a type of physician-developed clinical practice guideline, via a clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services (ADIS) in Medicare Part B. In addition, PAMA requires imaging providers to include AUC consultation information obtained from referring clinicians on claims for applicable imaging services to receive reimbursement ("real-time claims processing").

CMS made substantial operational and regulatory progress toward implementing the PAMA AUC program and built program infrastructure via notice-and-comment rulemaking between 2015 and 2020. The major components of the program, such as defining the scope of imaging subject to AUC, delineating and approving "Provider-Led Entities" (PLEs) to develop AUC content, and qualifying multiple CDSMs that integrated AUC into electronic ordering systems and EHRs, have already been established and led to a nationwide

educational and operations testing period starting January 1st, 2020. During that period, ordering professionals' participation was strictly voluntary and predictably lackluster due to the global pandemic.

Although most of the substantive policy design was completed, in the CY 2024 Medicare Physician Fee Schedule (PFS) Final Rule, CMS placed an indefinite pause on implementation of the AUC program due to difficulties implementing the real-time claims processing component of the program. In the same final rule, CMS acknowledged the value of the program both to the patient and Medicare via savings, supported statutory change to enable full implementation, and reserved the related regulations for future use.

Technology has far surpassed what was readily available in 2014, and ACR believes CMS should leverage the existing regulations currently reserved for future use and modernize the AUC program utilizing Section 1833 (t)(2)(F) of the SSA. Major components of the program such as the definition of the scope of imaging subject to AUC, approval of PLEs, and the qualification of multiple CDSMs to integrate AUC into electronic ordering systems and EHRs can be updated to align with changes in technology.

The major hurdle preventing full implementation, the "real- time claims processing" obligation should be replaced with an ordering provider's attestation of "conferring/reviewing" qualified AUC. The HHS Secretary can collect ordering data and determine the requirements for compliance. Additionally, the AUC consultation process should not be required for individuals with emergency medical conditions, ordering providers who participate in clinical trials, or providers in small and rural practices. Imaging services for screening should also be exempt.

Although implementation of the original PAMA statute faced challenges, with the above-mentioned updates, implementation is an obtainable goal and will reduce unnecessary utilization. Several health systems have voluntarily adopted a consultative AUC program to address unnecessary utilization of ADIS. Multiple studies have demonstrated improved ordering appropriateness scores with provider exposure to CDSM and that, when the AUC program is already in place, the consultative process can be adapted for advances in technology like artificial intelligence.

Most importantly, we believe mandatory consultation of AUC prior to the ordering of ADIS is in the best clinical interest of Medicare beneficiaries and provides savings to both the patient and the Medicare system. Although CMS indefinitely paused implementation of the PAMA AUC program, the agency acknowledged the benefits of the program and indicated significant estimated savings of up to $700,000,000 annually in the CY 2024 PFS final rule.

Updating and modernizing the AUC program are consistent with the Trump administration's focus on eliminating waste, fraud, and abuse by reducing unnecessary volume and associated costs while ensuring Medicare beneficiaries benefit from advances in

technology in the healthcare delivery system. The changes outlined above will ensure the AUC program can evolve with technology and improve patient care for generations to come.

HOPPS Payment for Software as a Medical Service (SaMS)

CMS proposes the following changes regarding software-based medical services with algorithmic analyses:

- CMS proposes changing the terminology from Software as a Service (SaaS) to Software as a Medical Service (SaMS).
- CMS proposes to use CY 2027 as a transitional period to take an incremental step toward developing a more comprehensive and appropriate payment methodology for services CMS proposes to identify as SaMS.
- For SaMS that are currently assigned to New Technology APCs for CY 2026, CMS proposes to maintain the current New Technology APCs for CY 2027 rather than assigning payment rates based on current claims data.
- CMS proposes to assign SaMS assigned to a New Technology APC to a proposed new status indicator "O1" – Software as a Medical Service, paid under OPPS; separate APC payment.

ACR Perspective and Comments

The ACR appreciates the CMS for inviting public and stakeholder feedback on the role of Software as a Medical Service (SaMS) and artificial intelligence (AI) in healthcare. This timely and important step will ensure emerging digital health technologies are integrated into care delivery in a safe, effective, and responsible manner.

The ACR agrees with the proposal from CMS to update its terminology to Software as a Medical Service (SaMS) to reduce confusion and facilitate more streamlined policy development. As a leader in AI governance, the ACR has developed a robust framework of tools, resources, and guidance to support informed decision-making and responsible adoption of AI across clinical settings. The rapid evolution of digital health technologies - including digital therapeutics, AI-enabled diagnostics, and systems ranging from augmentative to fully autonomous - has generated growing interest among physicians seeking to enhance patient care through innovation.

For these technologies to be meaningfully adopted and made available to patients, however, CMS must establish a clear and consistent pathway to payment. Reimbursement clarity is essential to support clinical integration, encourage innovation, and ensure equitable access to these tools.

CMS uses a highly complex methodology to develop the OPPS relative weights. At its basic level, CMS uses hospital charges on claims reduced to costs using cost-to-charge ratios (CCRs) from hospital cost reports. It then calculates the geometric mean cost among

claims within each APC. Because hospital charges are adjusted using CCRs, the resulting geometric means and respective Medicare payment rates will be significantly lower than the corresponding charge amounts.

Hospitals vary widely in how they report their charges and costs to CMS. Because of the difficulty accurately calculating all the capital costs associated with SaMS codes, most hospitals underreport this cost to CMS. The inconsistencies between the actual costs of SaMS tools and the geometric means calculated by CMS are concerning.

The ACR believes that, rather than assigning SaMS codes to radiology or other existing cost centers, CMS should consider establishing a new revenue cost center specifically for AI to allow more granular data to be obtained. This new cost center should only be applicable to SaMS codes that are augmentative (i.e., enhance patient care by performing tasks for which physicians are not already reimbursed). This would only be applicable to codes with a proposed "O1" status indicator deeming separate reimbursement.

In the meantime, CMS should maintain current APC placements for existing SaMS codes. The ACR supports the broad use of SaMS codes at an appropriate reimbursement rate so they may be adopted and utilized more widely by clinicians. The ACR believes CMS should allow adequate time for appropriate claims data to accrue before reassigning SaMS codes to new APCs. Refinements and exclusions based on low claims volumes should be applied consistently throughout the current fee schedule and across years. This would allow for more stability within the HOPPS with continuously emerging AI technologies.

The College believes CMS should clarify in the HOPPS final rule that the SaMS codes were designed by The American Medical Association (AMA) Current Procedural Terminology (CPT) to be vendor neutral. As a result, these codes do not belong to any single vendor or represent any single vendor's services. To focus on a single commercial platform for a code is not accurate, confuses the applicability of the code, and limits adoption of other tools for which the code was intended. By removing the current language that these codes are "associated with" a specific service, we anticipate an increase in claims, allowing CMS to gain a more accurate understanding of the actual costs associated with these services.

ACR continues to have concerns regarding the potential misuse of software-related HCPCS and CPT codes within the HOPPS. Specifically,, we have observed examples where software vendors have encouraged hospitals to report Category III AI-related codes in circumstances that appear broader than the clinical indications explicitly discussed by CMS when establishing payment policies. ACR previously raised concerns regarding utilization of CPT codes 0721T and 0722T, which CMS described as quantitative CT tissue characterization services associated with lung nodule malignancy risk assessment. However, vendors subsequently marketed these codes for use with a variety of assistive AI applications, including detection and measurement tools, creating uncertainty regarding appropriate billing and payment under the HOPPS.

As CMS expands policies related to SaMS, we urge the agency to establish clear guardrails that prevent software products from receiving duplicative payment when their functionality is already incorporated into the primary diagnostic or treatment service. Many AI-enabled applications serve as clinical decision-support, image analysis, workflow, or assistive tools that enhance provider efficiency but do not constitute distinct services furnished to the patient. Separate payment for such technologies absent clear evidence of a unique, independently payable service could create incentives for inappropriate billing and result in inconsistent application of HOPPS policy.

As artificial intelligence and software-enabled technologies continue to evolve, clear and consistently applied payment policies will be essential to support innovation while safeguarding program integrity and ensuring accurate HOPPS reimbursement. The ACR looks forward to continued collaboration with CMS, and we are ready to contribute our expertise to support thoughtful policy solutions that advance patient-centered care through responsible innovation.

Payment Policy for Diagnostic Radiopharmaceuticals

Separate Payment for Diagnostic Radiopharmaceuticals

For 2027, CMS proposes to pay separately for diagnostic radiopharmaceuticals with a per-day cost above $665. The proposed list of diagnostic radiopharmaceuticals that CMS calculated as having per day costs that exceeded $665 and their proposed status indicators can be found in Table 4 of the proposed rule.

CMS proposes paying qualifying diagnostic radiopharmaceuticals based on the arithmetic Mean Unit Cost (MUC) in CY 2027 while continuing to encourage manufacturers to submit Average Sales Price (ASP) data for possible future payment use. For new diagnostic radiopharmaceuticals with HCPCS codes that do not have pass-through status, claims data, or ASP, CMS will use Wholesale Acquisition Cost (WAC). If WAC is also unavailable, CMS will base payment on 95 percent of Average Wholesale Price (AWP).

ACR Perspective and Comments

We have appreciated CMS's engagement with stakeholders on this topic in the past and the opportunity to comment on this important issue in this year's proposed rule. **While ACR supports separate payment under the MUC methodology for products without ASP, we recommend that CMS allow for payment rates based on ASP, which has a more transparent methodology and reflects the widely available market price.** Stakeholders continue to have concerns that hospital outpatient claims data for certain products is limited and could result in fluctuations in payment from the average acquisition costs.

As with other drugs and biological products, the ASP methodology provides the most accurate reflection of the prevailing market price across widely available sources. Using ASP where available would be consistent with CMS precedent of pass-through payment status for drugs and biologicals. In conclusion, we strongly support CMS setting separate

payment for advanced diagnostic radiopharmaceuticals based on ASP data where available.

Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy

Proposed Increase in the Annual Conversion Factor Reduction from 0.5% to 3%

In the 340B Final Remedy rule, CMS finalized an annual 0.5 percent reduction to the OPPS conversion factor for non-drug items and services, beginning January 1, 2026, to recoup approximately $7.769 billion in increased non-drug payments made from CY 2018 through CY 2022 under the prior 340B payment policy. The reduction applies to hospitals enrolled in Medicare before January 2, 2018, and was estimated to complete recoupment by approximately CY 2041.

For CY 2027, CMS proposes to increase the annual reduction from 0.5 percent to 3 percent (proposed § 419.32(b)(1)(iv)(B)(13)), which CMS estimates would complete recoupment by the end of CY 2029 (Table 48 in the proposed rule). CMS also specifically seeks comment on the advisability of a 2 percent reduction. Under the proposal, the CY 2027 update for non-drug items and services at affected hospitals would fall from +1.9 percent under current law to −0.6 percent, for an effective conversion factor of approximately $99.015 rather than $102.004.

ACR Perspective and Comments

ACR understands that there are questions about CMS's legal authority to pursue this recoupment. While we have no particular views on this issue, our concerns are with the proposed pace and design of the repayment. Because the offset applies exclusively to non-drug items and services, diagnostic imaging and image-guided procedures bear this reduction directly at nearly every OPPS hospital, regardless of 340B participation.

The proposed acceleration would concentrate repayment into the same years in which CMS proposes its most significant outpatient payment changes: the repricing of 340B-acquired drugs to ASP minus 33.4 percent. We note that the hospital category impacts in Table 88, column 7 are modeled at the $102.004 conversion factor and therefore do not reflect the accelerated offset, which is presented separately in column 8. In addition, CMS has not published an analysis of the combined effect of these simultaneous policies. In the Final Remedy rule, CMS expressly balanced budget neutrality against hospitals' reliance interests and the burden of the offset (88 FR 77170). In the CY 2026 final rule, CMS advised hospitals to anticipate “a larger adjustment (such as 2 percent or other adjustment greater than 0.5 percent)” (90 FR 53714). A reduction six times the finalized rate, on a single year's notice, exceeds the change hospitals were told to expect. **The ACR recommends that CMS not finalize the proposed 3 percent annual reduction for CY 2027 and instead**

retain the 0.5 percent reduction. If CMS determines that acceleration is warranted, the ACR recommends that CMS finalize no more than the 2 percent alternative on which it seeks comment, or adopt a phased schedule (for example, 1 percent in CY 2027 and 2 percent in CY 2028), which would still complete recoupment roughly a decade ahead of current law. The ACR also recommends that CMS cap each hospital's cumulative offset at the incremental non-drug payments that hospital actually received during CY 2018 through CY 2022, discontinue the reduction for each hospital once that amount is repaid, and publish hospital-level estimates in advance.

Finally, while this rule exempts rural SCHs from both the imaging site-neutral proposal and the 340B drug payment proposal, the accelerated offset contains no comparable protection. Before finalizing any acceleration, the ACR recommends that CMS publish an analysis of the combined CY 2027 impact of the offset, the 340B drug payment proposal, and the imaging site-neutral proposal by hospital category (including safety-net hospitals, rural hospitals that are not SCHs, and major teaching hospitals), extend the rural SCH protection to the offset, and report annually on cumulative recoupment against the $7.769 billion target.

Hospital Outpatient Quality Reporting (OQR) Program Updates

Requests for Information (RFI) on Future Inclusion of an Advance Care Planning (ACP) Measure in the Hospital Outpatient Quality Reporting (OQR) Program

CMS is seeking feedback on whether an Advance Care Planning (ACP) measure should be considered for future inclusion in the Hospital OQR Program. Specifically, it references existing ACP measure concepts, including MIPS Quality Measure #047: Advance Care Plan, and requests input on whether such a measure could be adapted for the hospital outpatient department (HOPD) setting. The agency is also soliciting stakeholder feedback on the appropriate patient populations, procedures, service lines, or departments for which an ACP measure may be relevant, as well as potential implementation considerations in the outpatient hospital environment.

ACR Perspective and Comments

The ACR supports CMS's goal of promoting patient-centered care and advance care planning when appropriate. However, ACP discussions are generally not part of routine diagnostic imaging services and are typically conducted by providers with longitudinal responsibility for a patient's care. While some radiology subspecialties, such as interventional radiology, may have greater direct patient interaction, radiologists are not generally responsible for initiating or documenting ACP discussions.

The ACR suggests that CMS carefully consider attribution, accountability, clinical applicability, and measure validity when evaluating a potential ACP measure for the Hospital OQR Program. Because advance care planning discussions are typically conducted by providers with ongoing responsibility for managing a patient's overall care, it

may be difficult for many hospital outpatient departments, including imaging departments, to directly influence performance on such a measure. If CMS pursues this measure concept, the ACR recommends limiting it to providers, patient populations, and settings that have a meaningful opportunity and clinical responsibility to conduct and document advance care planning activities. Broad application across all outpatient hospital services could create unintended challenges for specialties, such as radiology, that generally have limited involvement in advance care planning discussions and could undermine meaningful accountability if performance is attributed to departments without control over ACP documentation.

The ACR appreciates the opportunity to provide comments on the CY 2027 HOPPS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process to create a stable and equitable payment system and promote an equitable delivery system. The ACR looks forward to continued dialogue with CMS officials about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kimberly Greck (kgreck@acr.org) or Christina Berry (cberry@acr.org).

Respectfully submitted,

Dana Smetherman, MD MPH MBA FACR FSBI
Chief Executive Officer, American College of Radiology

cc: Elise Barringer, CMS
Erick Chuang, CMS
Cory Duke, CMS
Kimberly Go, CMS
Nicole Marcos, CMS
Gil Ngan, CMS
Kristina Rabarison, CMS
Scott Talaga, CMS
Nate Vercauteren, CMS
Michael Booker, MD MBA ACR
Andrew Moriarity, MD ACR
Lauren Nicola, MD ACR
Christina Corcoran, MPH ACR
Judy Burleson, ACR
Kimberly Greck, ACR
Kathryn Keysor, ACR
Angela Kim, ACR
Maddie Loughery, ACR
Samantha Shugarman, ACR