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

Submitted online via www.regulatons.gov

RE: Code CMS-1850-P Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency: Proposed Rule

Dear Administrator Dr. Oz:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) representing more than 9,000 oral and maxillofacial surgeons (OMSs) across the United States, appreciates the opportunity to comment on the proposed CY 2027 revisions to the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems rule. We commend CMS for its continued efforts to improve access to high-quality, affordable healthcare. While AAOMS supports several aspects of the proposed rule, we also identify areas where further refinement could help reduce barriers to care across all settings.

Proposed Updates to OPPS and ASC Payment Rates

AAOMS supports CMS's proposal to increase facility rates for hospitals and ASCs that meet quality reporting requirements. This approach appropriately incentivizes high-quality care and aligns with value-based principles. AAOMS also commends CMS on its demonstrated commitment to recognizing the value of dental rehabilitation services, particularly the separately payable procedure G0330. The proposed OPPS payment rate of $3,849.31 reflects a meaningful step toward ensuring hospitals are adequately reimbursed for this medically necessary service.

However, we urge CMS to consider the unique challenges faced by OMS-owned ASCs and other facilities serving vulnerable populations or operating in resource-constrained environments.

Many such providers—including rural health clinics, Federally Qualified Health Centers (FQHCs), and smaller or independent ASCs—struggle with infrastructure limitations that hinder their ability to comply with reporting benchmarks, despite consistently delivering essential care.

In particular, OMS-owned ASCs often lack certified electronic health record (EHR) systems and therefore face significant barriers to participating in quality reporting programs. The cost and complexity of implementing certified EHR technology can be prohibitive for many ASCs, especially those with limited financial margins or serving high-risk populations. As a result, these facilities risk being excluded from payment incentives despite their commitment to safe, effective care.

Given these challenges, **AAOMS respectfully requests that CMS exempt OMS-owned ASCs from quality reporting requirements that depend on certified EHR technology**. At a minimum, CMS should establish flexible reporting pathways that allow these facilities to demonstrate compliance through alternative reporting mechanisms that do not require certified EHR systems. Providing such flexibility would ensure that OMS-owned ASCs can continue to participate in Medicare programs and quality improvement initiatives without being disproportionately disadvantaged by technological requirements that may not be feasible for their practice setting.

Proposed OPPS 340B Remedy Policy

AAOMS is also concerned about the impact of the OPPS 340B remedy policy and corresponding ASC weight-scaler methodology on ASC payment facility rates for dental services. Based on our review of the proposal, it appears that many dental procedures commonly furnished by OMS in ASCs may experience reductions in facility payment rates. These policy changes increase variability in payment rates for OMS-rendered procedures, creating unpredictability for doctors practicing in ASCs. The current methodology appears to privilege device-intensive designated procedures at the expense of others. All CDT services included on the ASC covered procedures list are not designated as device-intensive and will consequently see reduced payment rates compared to the final rates for CY 2026. Dental procedures are often rendered in ASCs for patients with medical complexities that require the resources and safety of a facility-setting. Reducing payment for these services may inadvertently reduce access to necessary dental procedures in the most appropriate setting for care.

Further, this proposed policy introduces greater site of service payment differentials that may create unintended consequences that undermine the goals of efficiency and patient access. Providers may be incentivized to shift services to higher paid settings based on reimbursement considerations. Larger payment gaps can also encourage market consolidation, as physicians and independent facilities may seek alignment with hospital systems that receive higher reimbursement, reducing competition and potentially increasing costs for payers and patients. In addition, widening differentials may place financial pressure on ASCs, limiting their ability to invest in new technologies, expand capacity or serve certain patient populations. **We encourage CMS to consider the broader impacts of the 340B remedy policy and ASC weight-scaler**

methodology and explore alternative policy adjustments to ensure stable payments for providers in ASC settings while preserving the integrity of the payment systems. Payment rates for other musculoskeletal and digestive procedures rendered by OMS also appear to increase or decrease depending on the classification of a service as device-intensive, further worsening the unpredictability faced by doctors.

Additionally, AAOMS identified potential inconsistencies in the device-intensive designations for certain craniofacial and mandibular reconstruction procedures. For example, CPT 21142 is classified as device-intensive while clinically similar procedures CT 21141 and 21143 are not. Likewise, CPT 21195 is designated as device-intensive whereas CPT 21196, which includes internal rigid fixation, is not. **AAOMS requests clarification on the designation of procedures as device-intensive and how those criteria are applied across clinical families, given the impact of the designation on payment rates. More broadly, AAOMS is concerned that the current methodology may worsen payment variability among clinically similar procedures and create inconsistencies within clinical families. We urge CMS to clarify the rationale for these designations and reconsider any classifications that may not accurately reflect the resources required to furnish these procedures.**

Phased Elimination of Inpatient Only List

AAOMS supports CMS's proposal to continue phasing out the IPO list in 2027. This policy reflects a thoughtful and clinically grounded approach to modernizing Medicare payment systems and expanding access to care in more cost-effective settings.

By allowing these procedures to be reimbursed in the hospital outpatient setting and/or ASC when deemed clinically appropriate, CMS is empowering physicians to exercise their professional judgment in selecting the most suitable site of service for each patient. This flexibility enhances patient-centered care and supports efficient resource utilization across the healthcare continuum.

Thank you for considering these comments. We look forward to continued collaboration with CMS to strengthen the outpatient care system and ensure that payment policies support both quality and sustainability. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality, and Reimbursement with any questions at 800-822-6637, ext. 4394, or pserpico@aaoms.org.

Sincerely,

Robert S. Clark, DMD
AAOMS President