The Hospital + Healthsystem Association of Pennsylvania

August 31, 2026

The Honorable 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 21244-8013

RE: CMS-1850-P, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems…; July 2, 2026.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital outpatient prospective payment system (OPPS) proposed rule for calendar year (CY) 2027.

Pennsylvania's hospitals and health systems are the backbone of the health care system, providing 24/7 care to patients and communities. Hospital care today is more advanced, more effective, and more resource-intensive than ever before, reflecting significant gains in medical innovation, as well as the highly skilled workforce, technology, and infrastructure required to deliver it. Patients are living longer, recovering faster, and receiving treatments that would have been unimaginable just a generation ago. As communities across the country face demand for health services, it is essential that Medicare payment policies support the sustainability and availability of these providers. Despite the growing need for care, in Pennsylvania alone over the past decade, 26 hospitals have closed, and another 12–14 hospitals are at risk of closure by 2030 if reimbursement continues to fall below the cost of providing care.

For CY 2027, CMS proposes a market basket increase of a net update of 2.4 percent. This is simply not enough. HAP has grave concerns about this inadequate update, especially when taken together with the underwhelming market basket increases from CYs 2022, 2023, 2024, 2025, and 2026. It does not capture either the unprecedented inflationary environment, nor the other persistent financial headwinds hospitals and health systems are experiencing. It also fails to account for the fact that labor composition and costs have remained extraordinarily high, and as a result, the hospital field continues to face sustained financial pressures and workforce shortages.

As such, HAP strongly urges CMS to strengthen the CY 2027 OPPS payment update by revisiting the market basket forecast and working with Congress to reduce the magnitude of the productivity adjustment. Current market basket increases, especially when reduced by the productivity adjustment, simply do not reflect hospitals' rising labor, drug, supply, and administrative costs. CMS must find ways to account for these increased costs to ensure that beneficiaries continue to have access to quality care.

We are also deeply concerned about CMS' proposed policies impacting the 340B Drug Pricing Program, including the proposal to reduce 340B reimbursement rates by a shocking 33.4 percent. CMS is basing the proposed reduction on an invalid drug cost acquisition survey, making it unlawful and opening the door to additional claw backs in the future. If the agency chooses to move forward with this enormous cut, it will be financially devastating for 340B hospitals. It will make drugs less affordable for America's most vulnerable patients, and force hospitals to make difficult decisions about whether to discontinue critical services or to reduce their already strained workforce. Additionally, CMS proposes to speed up its claw back from 0.5 percent to 3 percent, essentially punishing hospitals for an error CMS made in implementing a policy that a unanimous Supreme Court held to be unlawful. **HAP strongly urges CMS to reverse course on these policies which reduce payments to Pennsylvania hospitals by several hundred million dollars and jeopardize access to affordable care.**

In addition, we incorporate additional comments provided in the American Hospital Association's response to the proposed rule by reference.

Thank you for your consideration of HAP's comments about this proposed rule regarding outpatient payments and other provisions related to hospitals and the patients they serve in Pennsylvania.

If you have any questions, contact **me**, or **Brooke Bowers**, HAP's director, financial reimbursement and analysis.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance & Legal Affairs

Attachment

HAP Comments—Outpatient Prospective Payment System Proposed Rule for Calendar Year 2027

PROPOSED PAYMENT UPDATE

CMS proposes to increase payments by a net 2.4 percent in calendar year (CY) 2027 compared to CY 2026. This payment includes a 3.2 percent market basket update, minus a 0.8 percentage point productivity cut as required by the Affordable Care Act.

The Medicare Payment Advisory Commission (MedPAC) projects that 2026 Medicare margins will be less than negative 10 percent[1], resulting in more than 20 straight years of Medicare paying below costs. The American Hospital Association's (AHA) analysis showed that Medicare underpayments reached $100 billion in 2024.[2] This cannot be sustained.

HAP has grave concerns that CMS' proposed annual market basket update of 3.2 percent is not keeping pace with real-world cost growth. In recent years, CMS' market basket forecasts have consistently come in below broader inflation, let alone medical inflation, which has exceeded growth in the overall economy. Layered on top of that, the productivity adjustment, proposed to be 0.8 percentage points for CY 2027, further erodes the update, leaving Medicare payments increasingly out of sync with the cost of care. **This is simply not enough as nearly 57 percent of Pennsylvania hospitals have a negative Medicare margin on outpatient services. We urge CMS to revisit both its market basket forecasts and the magnitude of the productivity adjustment, and to consider their combined effect on provider reimbursements.**

Hospitals continue to face sustained inflationary pressures. Inflation has continuously pushed up labor, drug, supply, and other core operating costs. A recent AHA report found that total hospital expenses increased by 7.5 percent in 2025 alone. Much of this increase reflects labor costs, which rose by 5.6 percent in 2025. Further, advertised salaries for registered nurses have averaged 5.5 percent growth over the last two years—more than double the rate of inflation.[3]

Cost pressures, however, extend well beyond labor. Hospitals are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies, and these costs continue to climb. An AHA analysis showed that in 2025 supply costs rose 9.9 percent while drug costs rose a staggering 13.6 percent.[4] In addition, a report from the Department of Health and Human Services found that list prices for nearly 2,000 drugs increased by an average of 15.2 percent from 2017 through 2023—outpacing general inflation.[5] These cost

[1] March 2026 Report to the Congress: Medicare Payment Policy
[2] Costs of Caring | AHA
[3] Costs of Caring | AHA
[4] Costs of Caring | AHA
[5] Changes in the List Prices of Prescription Drugs, 2017-2023 | ASPE

challenges strain hospitals who must be prepared to provide treatment for a wide range of conditions and comorbidities.

The proposed increase does not capture either the unprecedented inflationary environment, or the other persistent financial headwinds hospitals and health systems are experiencing. It also fails to account for the fact that labor composition and costs have remained extraordinarily high and that, as a result, the hospital field continues to face sustained financial pressures and workforce shortages. CMS must focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the actual cost of providing hospital care.

REDUCED PAYMENTS FOR DRUGS ACQUIRED UNDER THE 340B PROGRAM

In Pennsylvania, 72 hospitals (in 30 counties) participate in the 340B program and serve our most vulnerable populations. About half are in rural areas—15 of which also offer critical labor and delivery services. Our state's 340B hospitals are the lifelines of their community, and the discounts they receive through the 340B program enable them to maintain a broad array of services for their patients.

In the proposed rule, CMS aims to cut reimbursement rates for drugs acquired under the 340B program by nearly *40 percent*—from the current Average Sales Price (ASP) plus 6 percent rate to ASP minus 33.4 percent rate. *HAP estimates that this rate reduction will cost Pennsylvania 340B hospitals nearly $400 million*

Further chipping away at the financial viability of hospitals will have negative downstream effects on the surrounding communities that will be hardest felt by low-income and older patients. Limiting the savings achieved through the 340B program would materially restrict our 340B hospitals from:

- Providing financial assistance to patients unable to afford their prescriptions.
- Providing clinical pharmacy services, such as disease management programs or medication therapy management.
- Funding medical services, such as obstetrics, diabetes education, oncology services, and other ambulatory services.
- Establishing additional outpatient clinics to improve access.
- Creating new community outreach programs.

The proposed rate decrease is not just detrimental; it is unlawful. Other stakeholders, including the AHA, have provided extensive comment on this proposal and HAP echoes the concerns of its allied associations. The agency has not satisfied the "important procedural prerequisite" for varying reimbursement rates by hospital groups (*Am. Hosp. Ass'n v. Becerra*, 596 U.S. 724, 735 (2022); *see* 42 U.S.C. § 1395l(t)(14)(D)(iii)) as it has not conducted a legally valid cost acquisition survey. While we defer to the AHA on the detail survey's validity, or lack thereof, we concur that it did not meet the statutory standard. The survey was not based on a "large" sample

of hospitals, and it did not generate a statistically significant estimate of the average acquisition cost for *each* drug as required by statute. The survey was also administered in the midst of significant supply chain disruptions and drug shortages further skewing the limited data on which results were based.

HAP joins the AHA in calling for the release of underlying drug cost acquisition survey data and any other information CMS relied on to reach the proposed reimbursement cut. CMS should delay implementation of this proposal until stakeholders have had an opportunity to review all of the pertinent information and provide comments.

The Department of Health and Human Services has recently made a series of other policy decisions that impose significant costs on 340B hospitals that must be considered in the context of the proposed rate decreases. The 340B Rebate Model that is slated to go into effect on January 1, 2027, will inflict massive administrative costs, "float costs," and non-economic costs on 340B hospitals. A report by 340B Health indicates that if the 340B program were to fully convert to a rebate model, an average size disproportionate share hospital (DSH) would, on average, float drug manufacturers $72.2 million dollars per year. For DSH hospitals with more than 487 beds, that average annual float cost would likely be closer to $208 million. At the same time, the agency is allowing Eli Lilly and other drug companies to impose unlawful, onerous, and expensive claims data requirements on hospitals, just so that they can receive discounts they are already owed by statute.

CMS must weigh the cumulative effects of these policy choices before moving forward with this 40 percent reimbursement reduction.

PROPOSAL TO INCREASE OPPS CONVERSION FACTOR FOR NON-DRUG SERVICES

CMS proposes to increase the OPPS conversion factor for non-drug services by 8.44 percent to make the cuts to 340B purchased drugs budget neutral. Statewide, the proposed increase would account for roughly half of what our hospitals stand to lose from the 340B drug rate cut. Based on our estimates, OPPS payments to Pennsylvania hospitals would decrease by $187 million if both proposals were finalized. HAP acknowledges that some hospitals in Pennsylvania would see an increase in OPPS payments in 2027 as a direct result of the proposed adjustment for non-drug services but are disappointed that the increase would come at a significant expense to others. The most sizeable loss from these proposals will be more than six times the most significant gain on a hospital-by-hospital basis.

Hospitals across Pennsylvania are in desperate need of rate increases, but we remain concerned that CMS' strategy is unsound and lacks long-term benefits. We would remind the agency that increasing reimbursement for non-drug services to offset a cut to reimbursement for 340B drugs is the same strategy that CMS attempted to implement eight years ago that was found to be unlawful. For all the reasons stated above, we remain concerned that deploying the same strategy will ultimately result in future claw backs long after the money has been spent.

Furthermore, HAP joins the AHA in questioning whether CMS will guarantee budget neutrality on an annual basis. As the AHA aptly points out, when this policy was previously in place, CMS never recalculated the budget neutrality adjustment to account for volume changes in drug claims and non-drug claims over time. In the end, the original adjustment did not reflect actual claims.

PROPOSAL TO ACCELERATE RECOUPMENT PAYMENT TIMELINE

In the outpatient payment rule, CMS proposes to expedite the recoupment of payments made for non-drug services during CY 2018–2022 that were part of the 340B Remedy Rule. Originally, CMS was going to recoup payments for non-drug services using an OPPS conversion factor of 0.5 percent until repayment was made over 16 years. Now, CMS is proposing to use an OPPS conversion factor of 3 percent, drastically shortening the repayment timeframe for no apparent legitimate reason.

The adjustment to the conversion factor will mean a $63 million dollar reduction in payments made to hospitals under the OPPS for CY 2027. HAP would like to take this opportunity to point out that this recoupment effort is a direct result of CMS unlawfully making similar changes to reimbursement rates for drugs purchased under the 340B program in 2018. These losses are in addition to other substantial cuts to hospital outpatient payments in this proposed rule as well as the fiscal impact of recent federal legislation including the One Big Beautiful Bill Act.

CMS lacks the statutory authority to impose claw backs on any timeline as the AHA has correctly explained and supported with references to current statute and relevant case law in its comments on this proposal. HAP joins the AHA in urging CMS to abandon this proposal. If CMS chooses to move forward with the recoupment, HAP urges CMS to maintain the existing claw back timeline to "account for reliance interests and ensure the offset is not overly burdensome to impacted entities" as the agency originally set out to do in 2023 when the claw back was first finalized.

METHOD TO CONTROL "UNNECESSARY INCREASES IN THE VOLUME OF OUTPATIENT SERVICES" FURNISHED IN GRANDFATHERED OFF-CAMPUS PROVIDER BASED DEPARTMENTS (HOPD)

For CY 2027, CMS proposes to expand the site-neutral payment policy to apply to reduce payment for imaging without contrast APCs (5521-5524) and APCs 8004 (ultrasound composite), 8005 (CT and CTA without contrast composite), and 8007 (MRI and MRA without contrast composite) furnished in excepted off-campus HOPDs to the "physician fee schedule (PFS) equivalent" rate of 40 percent of the OPPS amount in a non-budget-neutral manner.

CMS did not consider other reasonable explanations for the increase in the volume of imaging without contrast services in HOPDs**.** Specifically, we disagree that higher payments for these imaging services in HOPDs are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." This assertion ignores many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from Medicare, Medicaid and private payors, as well as excessive administrative burdens.[6,7,8]

CMS also does not adequately demonstrate that its comparison of Ambulatory Payment Classifications payments to PFS payments provides an appropriate basis for imposing site-neutral payment reductions. CMS cites payment differences between HOPDs and physician office settings to support its proposal. However, comparing rates for these services does not accurately capture differences in resource use, total spending, beneficiary cost sharing or obligations associated with furnishing care in each setting. Specifically, OPPS payments are based on hospital cost data that are submitted annually and include packaged items, services, supplies and supportive resources needed to furnish outpatient care. By contrast, PFS rates are based on relative value units (RVU) for physician work, practice expense and malpractice expense, which are determined in part using survey data over which CMS has expressed concerns regarding accuracy, representativeness, and reliability. The calculation of PFS rates is not designed to reflect the broader operational, regulatory, staffing, standby-capacity, and infrastructure requirements of HOPDs.

Thus, comparing payment rates for a single imaging procedure across the two systems does not provide a complete picture of relative resource use or total episode costs. CMS has not presented sufficient analysis showing that these payment differences reflect excess program spending rather than legitimate differences in patient complexity, service mix, emergency preparedness, compliance obligations, care coordination, and hospital-based resources.

The agency also did not take into consideration that HOPDs are more likely to serve Medicare patients who are sicker, more clinically complex, and more likely to be disabled or living in poorer, rural communities than patients treated in independent physician offices.[9,10]

Finally, CMS did not take into account that hospitals and health systems invest in their communities to provide essential benefits and advance health care for all Americans, all of

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[6] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf
[7] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care
[8] https://www.aha.org/news/blog/2025-10-21-physician-practice-acquisitions-what-drives-them-and-implications-consumers-and-payers
[9] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025
[10] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

which is unfunded. Among the types of community benefits and core clinical benefits hospitals and health systems offer are:

- Free or discounted medical services to low-income, uninsured, or underinsured individuals.
- 24/7 essential services, such as maintaining critical infrastructure like emergency departments, trauma units, burn centers, and neonatal care.
- Health screenings and education for their communities, such as sponsoring mobile wellness vans, vaccination drives, and chronic disease management seminars.

HAP urges CMS to withdraw this proposal from consideration. Expansion of the site-neutral payment policy to these procedures will result in a $34 million dollar reduction in payments to Pennsylvania hospitals.

REQUIREMENT FOR UNIQUE NATIONAL PROVIDER IDENTIFIERS (NPI) AND ATTESTATION FOR ALL OFF-CAMPUS HOPDs

Under the law, beginning January 1, 2028, each off-campus HOPD will be required to obtain and bill under its own NPI, along with meeting new initial and subsequent provider-based attestation requirements. **We support many of CMS' proposals that would reduce burden for the attestation process. That said, we have significant concerns about the separate NPI requirement related to the increased burden it will cause for hospitals and health systems, physicians, and other insurers.** Specifically, we are concerned that, while required under the law, a separate NPI would substantially and negatively impact hospitals and health systems and their patients.

This separate NPI requirement raises several serious concerns:

- Inconsistent NPI use across insurers would undermine the Health Insurance Portability and Accountability Act's (HIPAA) administrative simplification goal of a single provider identifier for all claims.
- Requiring different NPIs for different payors would disrupt coordination of benefits and prevent the same claim from being adjudicated across plans.
- Separate NPIs for each off-campus HOPD could add burden to physicians' and other professionals' claims submitted on the HIPAA standard professional claim.
- Because prior authorizations are often tied to a hospital NPI, different NPIs for the main campus and off-campus HOPDs could require separate approvals, delaying care when patients receive services across locations.
- Separate NPIs could also jeopardize split billing, preventing hospitals from combining services across HOPDs into one claim and increasing patient cost-sharing and billing complexity.

To prevent greatly increasing hospital regulatory burden and patient billing confusion, we encourage CMS to take the following steps:

- Establish a phased-in and transparent implementation process.
- Provide sufficient time for provider enrollment changes, payor configuration, and end-to-end testing.
- Issue additional guidance to both providers and health insurers to prevent needless amplification of administrative difficulty and potential delays in patient care and to ensure that all parties involved are adequately prepared.
- Exercise enforcement discretion during this transition period for providers.
- Create a standardized mechanism that links each off-campus NPI to the hospital's main campus NPI and ensure this crosswalk is available to Medicare contractors and other payors so that systems can recognize the same hospital organization.
- Convene stakeholders to identify and resolve claims processing issues.

PROPOSED CHANGES TO THE INPATIENT-ONLY LIST

HAP strongly opposes CMS' proposal to eliminate the inpatient only (IPO) list over three years. The IPO list was created to protect beneficiaries. Many of its services are complicated and invasive surgeries that may involve multiple days in the hospital, special protections against infections, and significant rehabilitation and recovery periods, requiring the care and coordinated services of the inpatient setting of a hospital.

While CMS reinforces the use of the two-midnight benchmark and the judgement of the physician or surgeon in determining whether hospital admission is appropriate, Medicare Advantage (MA) plans frequently do not adhere to the two-midnight benchmark and utilize other criteria to deny or underpay claims provided as an inpatient. This increases the administrative burden on providers who must challenge denials and underpayments in order to be paid appropriately for the care rendered.

Instead, HAP recommends that CMS continue its standard process for removing procedures from the IPO list. The agency should consider setting general removal criteria based upon, for example, average length of stay, peer-reviewed evidence, or patient factors such as age.

REQUEST FOR INFORMATION (RFI) ON STRENGTHENING THE STANDARDIZATION AND COMPARABILITY OF HOSPITAL PRICE TRANSPARENCY DATA

CMS is considering whether hospital price transparency data requires additional standardization to make the data more comparable and useful for patients, employers, researchers, and policymakers. The machine-readable format (MRF) RFI has two areas of focus: increasing transparency around outlier provisions and other contracting terms and improving standardization to enhance MRF utility.

In the first set of questions, CMS seeks information on contract features that can significantly affect payment rates, including outlier payment provisions, stop-loss arrangements, rate-tiering methodologies, and carve-outs, and asks how these provisions can affect individual service-level

rates. CMS also seeks feedback on what additional information or standardization is needed for MRF users to better understand these contract provisions and utilize the MRF data.

While HAP supports clearer definitions and standardization where data can be consistently reported, the fact remains that MRFs are limited in how they can translate negotiated rates and contract methodologies. Payor contracts are highly customized, and some terms cannot be reduced to a simple standardized field without creating inaccuracies.

- Outlier payments are triggered only in unusual clinical circumstances and do not apply to most cases.
- Stop-loss arrangements, case-rate adjustments, and carve-outs frequently operate at the claim level rather than the individual service-line level.
- Contract provisions interact with each other, making it difficult to attribute a single payment rate to a specific Current Procedural Terminology (CPT) or Diagnosis-Related Group (DRG). For instance, when multiple procedures are on a claim, the payor may reimburse one CPT at 100 percent and additional procedures at 50 percent.
- Excessive disclosure requirements could misrepresent actual reimbursement

From a patient perspective, a standardized list of contract terms, regardless of how extensive it may be, still does not give any indication as to which terms specifically apply to each individual case. If the end goal is for patients to better understand likely payment amounts, claims-based allowed amount data can show how contractual methodologies are applied without requiring providers to disclose each contract provision.

Additionally, from a practical perspective, standardizing reporting of payor, plan, product, network, and employer information across hospital MRFs would not be possible given the variation in insurance products from state to state.

In the second set of questions, CMS seeks comments on other opportunities to enhance consistency in MRF data to increase its utility and comparability. The consumer-friendly display RFI asks how CMS can improve the comparability of shoppable service data for patients. Specifically, CMS seeks information on the following topics:

- Whether to modify or eliminate the current deemed compliance pathway, which allows hospitals to satisfy requirements through an Internet-based price estimator tool.
- Whether to update the required list of shoppable services.
- Whether CMS should provide additional guidance on what the displayed prices must include, particularly for ancillary services, bundled services, and other related charges.

Hospitals and health systems have invested significant financial resources into price estimator tools to provide patients with personalized estimates of their expected out-of-pocket costs. These tools are more consumer-friendly and accessible for patients than large data files or spreadsheets. **HAP urges CMS to continue the current deemed compliance policy for Internet-based price estimator tools.**

CMS should not modify the number or list of CMS-shoppable services at this time. Hospitals are already required to make available consumer-friendly information for at least 300 shoppable services, and there is no evidence that adding to this list would meaningfully improve patient understanding of out-of-pocket costs.

Additionally, uninsured and self-pay patients already receive personalized good faith estimates prior to scheduled care, and once the advanced explanation of benefits requirements are implemented, insured patients will also receive estimates of their out-of-pocket costs for scheduled care. Those estimates will be the patients' best source of information about what they will pay for services.

HAP urges CMS to focus on tools that produce individualized patient estimates instead of adding complexity to the existing MRF requirements. Patients need access to clear, accurate health care price information in a manner that is understandable and avoids unnecessary administrative burdens on providers.