The Hospital + Healthsystem Association of Pennsylvania

September 15, 2025

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

Re: CMS–1834–P, Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency; Proposed Rule (Vol. 90, No. 133), July 17, 2025.

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) and ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2026.

We are deeply concerned about certain proposals that CMS has set forth in this rule. Taken together, they would negatively impact beneficiary access to hospital-level care and new technologies, while also greatly increasing hospital regulatory burden. Specifically, HAP opposes CMS' proposals to:

- Reduce payment for all drug administration services furnished in excepted off-campus hospital outpatient departments (HOPD) to the "physician fee schedule (PFS)-equivalent" rate of 40 percent of the OPPS payment amount.
- Eliminate the inpatient only (IPO) list over three years.
- Collect market based payment rate information by Medicare Severity Diagnosis Related Group on the Medicare cost report for cost reporting periods ending on or after January 1, 2026.
- Revise the requirements for hospitals to make public their standard charges.

These proposals raise even more urgent concerns when considered in the context of the significant Medicaid cuts recently enacted by Congress, which alone pose an existential threat to many hospitals in our commonwealth. Before Congress' Medicaid cuts, almost half of Pennsylvania's hospitals were running at financially unsustainable margins.

HAP is extremely disappointed that CMS has again proposed an inadequate update to hospital payments. For CY 2026, CMS proposes to increase the payment

rates under the OPPS by an Outpatient Department fee schedule increase factor of 2.4 percent. The fee schedule increase factor equals the proposed hospital market basket increase factor of 3.2 percent, reduced by a statutorily required productivity adjustment of 0.8 percentage points. Based on this update, CMS estimates that total payments to OPPS providers (including beneficiary cost sharing and estimated changes in enrollment, utilization, and case mix) for CY 2026 will be approximately $100 billion, an increase of approximately $8.1 billion compared to estimated CY 2025 OPPS payments.

The mere 2.4 percent increase for outpatient hospital services, which is effectively wiped out for hospitals impacted by the proposed 340B offset, is simply not enough to help hospitals in Pennsylvania and across the country that continue to operate on negative or very thin margins. Providing quality care and investing in workforce are only becoming more challenging and more costly. Hospitals' and health systems' ability to continue caring for patients and providing essential services for their communities—especially in rural areas—is in jeopardy, and ***we strongly urge CMS to provide additional financial support in the final rule.***

PROPOSAL TO IMPLEMENT THE "PFS-EQUIVALENT" PAYMENT RATE FOR DRUG ADMINISTRATION SERVICES IN EXCEPTED OFF-CAMPUS HOPDs

CMS proposes to reduce payment for all drug administration services furnished in excepted off-campus HOPDs to the "PFS-equivalent" rate of 40 percent of the OPPS payment amount. This proposal fails to consider other explanations for the increase in drug administration. HAP recognizes CMS' assertion that higher payments for these services are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." ***However, we disagree.*** This assertion ignores many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from both Medicare and private payors, as well as excessive administrative burdens.[1,2]

CMS' proposal equates care provided in hospital clinics with less complex care provided at independent physician offices and other freestanding sites. However, such care is not equivalent, and current OPPS payment rates consider these significant differences. As an example, unlike independent physician offices, hospitals are required to take many additional measures to make certain that medications are prepared and administered safely while also providing important care coordination services for their patients. Specifically, hospitals must take steps to ensure that a licensed pharmacist supervises drug preparation,

[1] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf
[2] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care

rooms are cleaned with positive air pressure to prevent microbial contamination, and employees are protected from exposure to hazardous drugs. In addition, hospitals must remain in compliance with important safety standards such as those required by the Food and Drug Administration, U.S. Pharmacopeia, and The Joint Commission.[3]

PROSPECTIVE ADJUSTMENT TO PAYMENTS FOR NON-DRUG ITEMS OR SERVICES

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 2 percent, drastically shortening the repayment timeframe and effectively cancelling out the proposed payment update for 340B hospitals.

HAP endorses the American Hospital Association's legal analysis and comments submitted in response to this proposal. We urge the agency to reconsider its position and rescind subsection 419.32(b)(1)(iv)(B)(*12*) altogether because the agency lacks the statutory authority for *any* such clawback on *any* timeline.

If CMS persists with this unlawful clawback, it should not accelerate the existing timeline. When it codified a 16-year timeline in the Final Remedy Rule, CMS stated that it sought to "comply with the statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities."

The agency's proposal fails to account for the financial fragility of 340B hospitals and does not give them adequate time to prepare for a change in reimbursement rates of this magnitude. More than 50 percent of Pennsylvania 340B hospitals operate with negative margins. The 2 percent adjustment to the conversion factor will mean a $44 million dollar reduction in payments made to 340B hospitals under the OPPS for CY 2026. Our hospitals' medium- and long-term financial planning decisions factored in a 0.5 percent clawback. The proposal for expedited recoupment upsets settled expectations with little time to readjust—creating serious cash flow problems.

For hospitals, access to the savings the 340B program offers is the difference between a positive and a negative operating margin and a deciding factor when they consider what service lines to maintain. ***The expedited recoupment will have a meaningful***

[3] https://www.aha.org/system/files/media/file/2023/11/aha-ashp-letter-opposing-site-neutral-legislation-11-14-2023.pdf

negative impact on margins and will impact patient access to care—particularly in rural areas. In addition, the proposed rule *nowhere* considers the recent passage of the One Big Beautiful Bill Act, which will have direct, adverse impacts on our hospital's finances.

OPPS DRUG ACQUISITION COST SURVEY

CMS should abandon its proposal to conduct a drug acquisition cost survey of all hospitals paid under the OPPS. The survey will inflict unnecessary costs on hospitals and their employees, all with the apparent (and ill-advised) goal of cutting Medicare payments to certain groups of hospitals beginning in CY 2027.

Cost acquisition surveys are, in a word, costly. The proposed rule estimates that each hospital will require 73.5 hours to complete the survey at an approximate cost of $4,000. In its 2006 report to Congress about the lessons learned when conducting hospital acquisition cost surveys, the Government Accountability Office stated that the surveys "created a considerable burden for hospitals."

CMS appears to be conducting this survey in the service of reducing Medicare reimbursements in CY 2027 and beyond. But Medicare payments *already* lag far behind the costs hospitals incur for providing care to Medicare beneficiaries. Medicare reimbursement continues to lag—covering just 83 cents for every dollar spent by hospitals in 2023, resulting in over $100 billion in underpayments. From 2022 to 2024, general inflation rose by 14.1 percent, while Medicare net inpatient payment rates increased by only 5.1 percent—amounting to an effective payment *cut* over the past three years. The extent of Medicare underpayments was further noted in December 2024, the Medicare Payment Advisory Commission preliminary presentation to commissioners which stated that hospital Medicare margins had sunk to an all-time low of negative 12.6 percent and were projected to remain at that level in 2025.

CMS identifies no statutory authority for making participation mandatory. Section 1833(t)(14)(D)(iii), the only statute cited in that discussion, does not provide the agency with the authority to *mandate* hospital responses. All it does is set forth the requirements for a survey. If Congress wanted to require hospital participation in a drug acquisition cost survey or allow the Department of Health and Human Services Secretary to take enforcement action for a non-response, it would have done so, as it has in other contexts. **Absent such statutory authority, and absent any way to enforce a manufactured response-requirement, the agency must explicitly acknowledge in the final rule that responding to any cost acquisition survey is purely *voluntary***.

VIRTUAL DIRECT SUPERVISION

HAP supports CMS' proposal to make permanent the availability of virtual direct supervision for critical care, intensive care recovery, post-recovery services, and diagnostic services via real-time audio-video communication. Virtual direct supervision has proven to be an effective means of expanding access to care, especially in rural or underserved areas where physician availability is limited. This flexibility has allowed health care providers to continue offering essential services while overcoming logistical barriers. By permanently extending the definition of direct supervision to include virtual formats, CMS will facilitate greater access to critical care services, particularly for underserved populations that would otherwise face challenges in accessing in-person supervision. Ensuring that virtual supervision includes real-time audio-video communication (excluding audio-only) guarantees that health care providers can offer dynamic oversight while maintaining the standard of care.

PROPOSED REVISIONS TO THE QUALITY REPORTING PROGRAM MEASURES AND METHODOLOGY

HAP supports CMS' proposed modifications to the Quality Reporting Programs (QRP) and believes they reflect thoughtful efforts to refine the metrics and measures in alignment with the evolving health care landscape. Specifically, we endorse the proposals for the Outpatient, ASC, and Rural Emergency Hospital (REH) QRPs.

While we agree that timely access to emergency care is essential for improving patient outcomes, ***we are concerned that the introduction of the "Emergency Care Access and Timeliness" electronic clinical quality measure (eCQM) may pose a disproportionate burden on rural hospitals and providers participating in the REH Quality Reporting Program.*** Many rural facilities operate with limited staff, infrastructure, and technological resources, which can make the implementation and reporting of complex eCQMs especially challenging. Although alignment across quality programs can support consistency, applying this measure uniformly may not fully account for the operational realities faced by rural hospitals. We urge CMS to consider flexible implementation strategies, provide robust technical assistance, and ensure that rural providers are not unfairly penalized for challenges beyond their control.

HAP recognizes the importance of monitoring radiation exposure to support patient safety in outpatient and ASC settings. ***HAP is concerned that extending mandatory reporting for the "Excessive Radiation" eCQM through CY 2027 may place a significant administrative and operational burden on providers.*** Given the complexities and resource demands associated with eCQM reporting, we urge CMS to

carefully consider whether the benefits of continued mandatory reporting outweigh these challenges, especially in lower-resource settings.

Although we support efforts to improve patient education and engagement, ***we have concerns about the proposed mandatory adoption of the patient-reported outcome measure focused on "Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery."*** Implementing this measure may introduce added complexity and reporting burden for ASCs, particularly without sufficient evidence of feasibility and readiness across diverse facility types. ***HAP asks CMS to recommend further evaluation and stakeholder engagement before adopting this measure on a mandatory basis.***

HAP is cautious about the potential implications of CMS' two-phase approach in its efforts to enhance the Overall Hospital Star Rating methodology by placing greater emphasis on the Safety of Care measure group. Adjustments that significantly reweight specific domains may inadvertently disadvantage certain hospitals and create confusion among patients and stakeholders. We encourage a more transparent and collaborative process to ensure that any changes promote fairness, reduce reporting burden, and maintain the integrity of the Star Ratings system.

PROPOSAL TO ELIMINATE THE IPO LIST OVER THREE YEARS

HAP strongly opposes CMS' proposal to eliminate the 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 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.

PROPOSAL TO REVISE THE REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC THEIR STANDARD CHARGES AND CMS' ENFORCEMENT OF HOSPITAL PRICE TRANSPARENCY REGULATIONS

HAP is committed to advancing price transparency and shares the Administration's goal of giving patients clearer, more actionable cost information. While certain refinements to the transparency rule are useful, CMS should focus on policies that directly help patients rather than increasing administrative burden without improving understanding of costs.

CMS proposes updating the machine-readable file attestation language, requiring hospitals to affirm they have provided "all necessary information" for the public to derive service prices. We believe that this proposed update to the statement is unnecessary and problematic. Most importantly, it fails to account for the reality of hospital billing, which depends in significant part on insurer behavior and calculations, which in turn depend on a host of factors that cannot be easily calculated by a third party. ***We urge CMS to retain the current "good faith effort" attestation, which reflects what hospitals can realistically provide.***

In addition, CMS proposes to require chief executive officers or other senior executives to sign the attestation. This would be unnecessarily burdensome. We ask that the agency not add to the burdens of hospital leaders; instead, CMS should trust the good faith of others within the hospital who are far closer to the information and can verify its accuracy far more easily than someone higher on the organizational chart with broader responsibility. **Therefore, we encourage the agency not to finalize this proposal.**

In 2026, CMS would require hospitals to publish median, 10th percentile and 90th percentile allowed amounts, plus a count of the claims used for the calculations. We have several concerns regarding the methodology, and we point you to the comments from the American Hospital Association regarding issues related to patient privacy, the lookback period for data, and the methodology for calculating medians and percentiles. ***In addition, we strongly request that CMS allow hospitals at least one year to adopt the new data elements.*** At a time when hospital resources are stretched thin, we are concerned about the additional burden the new requirements would place on our staff, especially given the short timeline for implementation.

RFI: SOFTWARE AS A SERVICE (SaaS)

HAP supports CMS' request for feedback on alternative and consistent methods of payment for Software as a Service (SaaS) in light of the increasing utilization of software-based technologies, including artificial intelligence (AI), in health care delivery. As SaaS solutions continue to become integral in

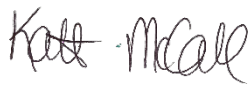
supporting health care operations—whether it be patient management systems or AI-driven diagnostics—there is an urgent need for a payment structure that ensures sustainable reimbursement for SaaS products that provide essential functionality to health care providers.

We encourage CMS to engage with SaaS providers, especially those focused on health care-specific solutions, to develop accurate cost data models. This will ensure transparency and consistency in calculating the cost of SaaS solutions, accounting for software development, licensing, updates, maintenance, and scalability.

Additionally, as SaaS solutions vary widely in their application and integration into health care systems, ***HAP urges CMS to consider a flexible methodology for assessing value***—one that recognizes not just cost savings but also improved quality of care, patient outcomes, and operational efficiencies. Aligning payment methodology with these metrics will better reflect the evolving role of software-based technology in health care.

We appreciate your consideration of these comments. Please contact **us** if you have questions.

Sincerely,



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