Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

August 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs

REF: CMS-1850-P

Dear Dr. Oz:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the calendar year (CY) 2027 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) System and other policies.

We appreciate your staff's ongoing efforts to administer and improve these payment systems, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on the proposed rule.

- **OPPS Update**

CMS proposes updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.4%. This update is based on the projected hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment.

The proposed update is woefully inadequate and falls significantly short of covering the true cost of delivering care, threatening the financial stability of health systems and putting patient access to critical services at risk. Since FY 2021, CMS has consistently underestimated actual hospital labor cost growth in its market basket updates, creating a cumulative funding gap that fails to reflect operational realities. This is particularly problematic given the persistent, severe inflationary pressures on labor and supplies across hospital outpatient departments. The result is a cumulative funding gap that fails to reflect operational realities.

Given recent history and the large difference between the forecasted market basket and the actual market basket, CMS should acknowledge these forecast errors and adjust the 2027 update upward in the final rule so that hospitals are not permanently behind due to earlier missed inflation.

CHA also reiterates the concerns expressed in our recent letter on the FY27 Inpatient Prospective Payment System (IPPS) proposed rule with the continuing application of the productivity adjustment. The Affordable Care Act requires the IPPS payment update is reduced by a productivity factor equal to the "10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year)." The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

However, CMS' Office of the Actuary (OACT) itself takes issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.

CHA recognizes that the statute requires CMS to apply the total factor productivity offset. **Nevertheless, CHA requests that CMS consider OACT's analysis and encourage Congress to change the law to change the productivity offset to one that is achievable by the hospital sector.**

- **Acceleration of 340B Recoupment**

The deficiency in the payment update is exacerbated by the proposed 3.0 percentage points reduction to recoup additional spending on 340B acquired drugs, resulting in a net payment update of -0.6 percent.

The additional 3.0 percentage point reduction arises from CMS' prior policy, in place from January 1, 2018 through September 27, 2022, reducing payment for 340B acquired drugs from average sales price (ASP) + 6 percent to ASP-22.5 percent and redistributing the savings to all OPPS hospitals as increased payment rates for non-drug services. In 2022 the U.S. Supreme Court ruled in *American Hospital Association v. Becerra*, 596 U.S. 724 that CMS did not have the legal authority to reduce payments for 340B-acquired drugs.

In response to that ruling, CMS adopted a policy to provide a lump sum payment for the amounts owed to 340B hospitals for the wrongfully withheld reimbursements. CMS also adopted a policy

to make these payments budget neutral by applying a reduction of 0.5 percentage points to the OPPS update beginning in CY 2026 for an estimated 16 years to recoup the redistributed remedy payments of $7.8 billion. CMS now proposes to increase the reduction in the update from 0.5 to 3 percentage points so it can complete the recoupment by CY 2029.

As a matter of principle, **CHA strongly opposes this additional reduction to the OPPS update.** CHA does not believe hospitals should be penalized for past actions taken by CMS in which they had no part and that were found to be inconsistent with statute by the Supreme Court. Further, CHA questions whether CMS has the legal authority to apply this additional 3.0 percentage point reduction to OPPS rates for the following reasons:

Medicare Statute Requires the Same Update to be Applied under the IPPS and OPPS. By law, CMS is required to update OPPS rates by the same update that applied under the IPPS. As CMS has already finalized an update of 2.3 percent for the FY 2027 IPPS, CMS must apply the same update to the OPPS for CY 2027.

Long-Standing Provisions of Law and CMS Precedent Do Not Allow the Agency to Recoup Past Payments Unless Explicitly Authorized by Congress. CMS has applied budget neutrality as a prospective concept (e.g., CMS uses past year information to make a prediction about the future, and it does NOT revise that adjustment for later events or information unless expressly authorized by Congress). This has been longstanding CMS policy in many contexts.

For instance, CMS routinely indicates in its annual rulemaking on the IPPS that it does not adjust future IPPS payments if spending on outliers is more or less than the amount CMS estimated and removed from the IPPS rates to fund outliers. For example, CMS states the following in the FY 2025 IPPS final rule:

> Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2025 are equal to 5.1 percent of total MS–DRG payments…We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment.[1]

The below are examples where CMS either understated or overstated Medicare spending because of a prior budget neutrality adjustment but did not take any action to recoup that additional spending or provide additional payment to rectify underpayments:

- CY 2016 OPPS Rule and Clinical Diagnostic Laboratory Services. CMS understated the necessary budget neutrality adjustment for packaging laboratory services in CY 2014 resulting in higher OPPS payments than intended. CMS applied a *prospective* adjustment to ensure it did not continue making these higher OPPS payments but indicated "The

[1] 91 FR 50384.

proposed -2.0 percent adjustment to the conversion factor would not recoup ''overpayments'' made for CYs 2014 and 2015" [2]

- Transitional Care Management (TCM) and Chronic Care Management (CCM). Codes for TCM and CCM were first created and paid using the Physician Fee Schedule (PFS) in 2013 and 2015 respectively. CMS' preemptive budget neutrality adjustment for these services vastly overestimated utilization. As CMS has not revised budget neutrality after the fact even though these adjustments resulted in permanent reductions to PFS payments.
- Complexity Adjustment under the PFS: The American Medical Association (AMA) provided a letter to CMS on May 9, 2025, indicating that CMS overestimated the adjustment required to maintain budget neutrality for payment of HCPCS code G2211 for patient complexity. The AMA estimates an underpayment to physicians of approximately $1 billion.[3] CMS responded to the AMA's comment acknowledging that they overestimated utilization of HCPCS code G2211 but stated "we do not make retrospective budget neutrality adjustments and would not compare actual claims reported for new coding against the utilization estimates made in the PFS final rule for the year in which such reporting began."[4]

However, the Tax Relief Act of 2012 explicitly authorized CMS to make prospective budget neutrality adjustments to recoup past increases in IPPS payments. In a final rule published on August 19, 2013, CMS acknowledged that it could not recoup past increases in spending until it received explicit authorization from Congress to adjust future payments to recoup past excess spending.[5] CMS recouped $11 billion in past IPPS spending due to documentation and coding from 2014 through 2017 as authorized by the Tax Relief Act through adjustments to the annual IPPS update.

As current statute and longstanding policy do not allow CMS to make prospective adjustments to hospital rates to recoup past additional spending, **CHA opposes the extra 3.0 percentage point reduction CMS proposes to apply to the 2027 OPPS update to recoup past additional spending for 340B acquired drugs**. CMS should adhere to its current recoupment policy.

- **Medicare Payment for 340B-Acquired Drugs**

Under the Medicare statute, CMS may either set OPPS payment rates for Part B drugs based on a survey of hospital acquisition costs, or, if hospital acquisition costs are not available, a default payment rate, currently ASP +6 percent. CMS' failure to conduct such a survey led to the Supreme Court finding that the prior 340B payment policy was unlawful.

---

[2] 80 FR 70354.
[3] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfb.zip/2025-5-9-Letter-to-Klomp-re-HCPCS-G2211.pdf
[4] 90 FR 49463
[5] 78 FR page 50514.

In the 2026 OPPS rule, CMS indicated its intent to conduct a survey of the acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS from January 1, 2026 through March 31, 2026. CMS further indicated its intent to propose Part B drug payment policies based on this survey for setting 2027 OPPS rates.

The proposed rule describes the drug acquisition cost survey design and implementation, CMS' data analysis and methodology, the survey results and its proposal. CMS is proposing to pay for 340B-acquired drugs at ASP-33.4 percent and maintain the ASP+6 percent payment rate for all other drugs. The proposed payment policy would not apply to vaccines, drugs with transitional pass-through payment status, and non-opioid pain management drugs. CMS also proposes to exempt children's hospitals and PPS-exempt cancer hospitals from the proposed policy. Finally, the proposal would apply to off-campus non-excepted PBDs that are not paid under the OPPS but under an "applicable payment system" that pays 40 percent of the OPPS. The proposal will be budget neutral with respect to hospitals paid under the OPPS but not off-campus non-excepted PBDs. CMS proposes a budget neutrality adjustment of +8.44 percent under the OPPS to non-drug OPPS services. **CHA strongly opposes CMS' proposed drastic reduction to Medicare payment for 340B-acquired drugs.**

The purpose of the 340B drug discount program "is to maximize scarce Federal resources as much as possible, reaching more eligible patients, and provide care that is more comprehensive."[6] Importantly, hospital eligibility is limited to those hospitals with a disproportionate share hospital (DSH) percentage that is 11.75 percent or higher (8.0 percent or higher for rural referral centers and sole community hospitals) that are owned by a state or local government or are non-profit hospitals under contract with a State or local government to provide services to low-income patients who are not eligible for Medicare or Medicaid. Thus, the 340B program is specifically designed to give resources to non-profit and government hospitals that serve high proportions of low-income patients to provide services to low-income patients that are otherwise not being served by public health insurance programs. CHA member hospitals provide services to low-income and rural communities consistent with the purposes of the 340B program.

Congress established the 340B program as noted above "to enable [covered entities] to stretch scarce Federal resources as far as possible, reaching more eligible entities and providing more comprehensive services." (H.R. Rep No. 102-384(II) at 12 (1992)). As a practical matter, CMS' proposal undermines the Congressional intent of the 340B program by taking drug discounts intended for hospitals that serve low-income patients and giving them to all hospitals paid under the OPPS. This occurs because CMS proposes to make the savings associated with its 340B proposal budget neutral through an upward adjustment under the OPPS to payments for all

[6] The House report that accompanied the authorizing legislation for the 340B Program stated: ''In giving these 'covered entities' access to price reductions the Committee intends to enable these entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.'' (H.R. Rept. No. 102–384(II), at 12 (1992)).

hospitals. CMS' action is inconsistent with the statutory purpose of the 340B program. Any action to change how the 340B program operates should be undertaken by Congress, not CMS.

If CMS proceeds to finalize its proposal, 340B-eligible hospitals will have fewer resources to provide services to low-income and rural communities than they do today For some hospitals, loss of these resources could challenge their very existence. In the end, it is not only 340B hospitals that will be most harmed by CMS' proposal, but also the communities they serve.

CHA also has concerns with the cost acquisition survey CMS conducted to justify the 340B payment reduction. The survey failed to meet the statutory requirement of a "large" sample of hospitals because its sample size was not large enough to produce estimates for "each" drug; some had to be excluded because they received fewer than 10 survey responses. Furthermore, CMS has not disclosed the underlying survey data that would allow stakeholders to identify additional problems with the survey and thus to comment effectively. Relying heavily on responses from smaller and rural facilities fails to reflect the higher cost structures, clinical intensity, and administrative burdens borne by large, complex, tertiary specialty health systems. Moreover, the survey omitted critical cost drivers including specialized handling, storage, hazardous waste disposal, administrative overhead, and regulatory compliance infrastructure that significantly increase the true cost of drug acquisition and management across large systems. Evaluating 340B drug costs without incorporating these comprehensive operational expenses yields an incomplete and inaccurate economic foundation for national policy decisions.

CHA urges CMS not to finalize this policy. But if it does, we are concerned the budget neutrality adjustment will be insufficient. When CMS, following the Supreme Court decision annulling the earlier 340B reduction, implemented its policy to recoup the redistributed funds its calculations indicated CMS had underestimated the savings which meant hospitals were underpaid because the budget neutrality adjustment was too low for the years when the 340B reduction was in effect.
.
If CMS finalizes its 340B payment policy, there will be significant risk that CMS' budget neutrality adjustment will again be inaccurate. Should CMS go forward with its proposal, CHA urges the agency to revise its budget neutrality adjustment based on after-the-fact data to ensure hospitals are neither advantaged nor disadvantaged by its budget neutrality adjustment. Anticipating that CMS may respond that its position is that it does not revise budget neutrality adjustments based on after-the-fact data, CHA requires an explanation why the same budget neutrality principle CMS is using to recoup past 340B spending after-the-fact does not apply here.

- **Payment Reduction for Imaging Services without Contrast**

CMS proposes to extend site-neutral payment policy to imaging without contrast services delivered in previously excepted off-campus provider-based departments in non-budget neutral

manner. **For all the reasons below, CHA opposes CMS' proposed expansion of its site neutral policy to imaging services without contrast**:

Hospital Outpatient Departments and Physician Offices are not the Same. CMS' policy does not recognize the key differences between physician practices and off-campus PBDs that result in higher overhead expenses for off-campus PBDs such as standby services incurred in 24-hour emergency department settings, requirements to employ wide range of staff and equipment that are not available in physician offices and comprehensive licensing, accreditation, and regulatory requirements that do not apply to physician offices.

Congress Specifically Exempted Existing Off-Campus PBDs from Site Neutral Policies. Existing off-campus PBDs opened before November 2, 2015 were specifically exempted ("grandfathered") from site-neutral payment under section 603 of the Balanced Budget Act of 2015. By applying site neutral payment for imaging without contrast services in *exempt* off-campus PBDs, CMS disregards the explicit grandfathering provision for exempt off-campus PBDs established by Congress.

CMS' Policy is not A Method to Control Unnecessary Increases in Volume. Section 1833(t)(2)(F) of the Act) authorizes the Secretary to "develop a method for controlling unnecessary increases in the volume of covered OPD services." A payment reduction is not a "method" for controlling utilization. A method to control increases in the volume of services is one that applies system wide.

Payment Change is an "Adjustment" Subject to Budget Neutrality. CMS argues that its reduction in payment for imaging without contrast services is not subject to budget neutrality because it is not an "adjustment" and only adjustments are subject to budget neutrality. However, CMS is applying the "PFS relatively adjustor" of 40 percent to determine the site-neutral payment for imaging without contrast services. The result of applying an adjustor is an adjustment.

CMS Provides No Clinical Basis for Increased Utilization of Imaging without Contrast Services as being Unnecessary. CMS has not conducted any medical review or distinguished any characteristics of the patients to determine that treatment in the outpatient department is unnecessary. Many patients receiving these services may be coming to the outpatient department for other services that require treatment in a hospital and imaging services are necessary to diagnose their condition. Absent more detail on the specific condition of the patient, CHA does not believe CMS can conclude that the higher utilization growth of imaging without contrast services furnished in the outpatient department is "unnecessary."

- **Inpatient Only (IPO) List**

Services were placed on the IPO list because they require inpatient care due to the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time, or the underlying physical condition of the patient requiring surgery. Procedures on the IPO list were

rarely, if ever, performed outpatient. Many services on the IPO list are surgical procedures that can be complex and require high levels of care and coordinated services. CMS annually reviewed the IPO list to identify any services that should be removed from or added to the list based on the most recent data and medical evidence available using criteria specified annually in the OPPS rule.

For CY 2021 CMS finalized a policy to eliminate the IPO list over the course of three years, citing its belief that the decision to provide care on an inpatient or outpatient basis should be left to the clinical judgment of the physician based on consideration of a patient's particular needs and condition. he agency rescinded that policy the following year, restoring most of the codes that had been removed from the IPO list and codifying CMS' long-standing criteria for evaluating future changes to the IPO list on a code-by-code basis. CMS subsequently maintained the IPO list on an ongoing basis through CY 2025.

In the 2026 OPPS rulemaking cycle, CMS again proposed and finalized a policy of eliminating the IPO list, beginning in 2026 through a three-year transition to be completed by January 1, 2029. CMS asserted that the evolving nature of the practice of medicine mitigates any potential patient safety and quality of care risks. In the first year of the three-year process, CMS removed 285 musculoskeletal procedures and 16 non-musculoskeletal procedures from the IPO list. Currently, 1,438 services remain on the IPO list. In the OPPS proposed rule for 2027, CMS proposes to remove an additional 637 services from the IPO list.[7]

While CHA continues to believe physicians' clinical judgment should play a role in determining where patients receive care, **we also continue to have concerns with the elimination of the IPO list, which presents a number of pricing and patient safety issues that will be difficult, if not impossible to adequately address, and believe CMS should reconsider its decision to phase out the IPO list.**

CMS' phase out of the IPO list will require the agency to establish OPPS prices for all HCPCS codes. CHA does not believe it will be necessary to establish OPPS prices for services that have little to no likelihood of being performed on an outpatient basis. For instance, CPT code 33945 is for "Transplantation of heart." There is no circumstance where a heart transplant would be performed on an outpatient basis in the current medical environment. CMS' policy to eliminate the IPO list and price all services under the OPPS would require the agency to unnecessarily price a heart transplant as an outpatient service. There may be many other services currently on the IPO list where OPPS pricing is unneeded as the state of medical technology and current standards of care do not allow the procedure to safely be performed on an outpatient basis. Alternatively, there may be many services at the opposite end of the spectrum that are less intensive where performance on outpatient basis is more likely for specific patients with existing technology. CMS' prior process was designed to remove such procedures from the IPO list on

[7] These services are in the following clinical families: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary.

the margin between always performed inpatient and able to be performed outpatient in some cases, while preserving the inpatient requirement for complex cases.

CHA contends that the pricing issues involved in setting OPPS payment rates for former IPO list services have become more apparent with the second year of CMS' phase out. For example, in the current proposed rule, CMS does not discuss the process the agency went through to assign the current tranche of IPO list removals to APCs, nor does the agency discuss the differentials in the cost of these procedures relative to their current IPPS payments, or what Medicare would pay for these procedures under the OPPS. In addition to running the risk of having to price services under the OPPS that would never be done on an outpatient basis, CMS also runs the risk of setting prices under the OPPS that simply would not reflect the resources involved in providing complex surgical procedures.

CMS does not provide any explanation of how the procedures being removed from the IPO list in 2026 were assigned to APCs, nor does it provide this information for the currently proposed removals, but it is apparent that many the procedures proposed for removal from the IPO list would be paid significantly less under the OPPS than the IPPS.

Payment reductions will provide strong disincentives to hospitals to allow these procedures to be performed on an outpatient basis if Medicare's payment for the procedure is significantly below the hospital's costs. Further, the hospital will lose any indirect medical education or disproportionate share payment associated with an inpatient procedure being performed outpatient further discouraging these procedures to move from the inpatient to outpatient setting. Finally, CMS will be expending significant resources to price services in the outpatient department that have little to no likelihood of being performed on an outpatient basis (like a heart transplant) given current medical technology and the state of patient care.

In prior rulemaking, CMS stressed that removal of a service from the IPO list has never meant that a beneficiary cannot receive the service as a hospital inpatient—as always, the physician should use his or her complex medical judgment to determine the appropriate setting on a case-by-case basis. **CHA agrees with this statement** and asks CMS to reiterate this guidance again in the CY 2027 OPPS final rule. Further, CHA asks that CMS make this policy clear to Medicare Advantage Organizations (MAOs) so that MAOs do not routinely require services to be performed outpatient that were formerly only paid for on an inpatient basis. Just because some patients can be treated on an outpatient basis does not mean that an MAO can require all patients to be treated in this setting. This admonition was not repeated in the OPPS proposed rule but CHA believes it needs to be emphasized again in the OPPS final rule.

- **Ambulatory Surgical Center List**:

Prior to CY 2026, 42 CFR §416.166(d) excluded procedures from the covered procedures list (CPL) that:

1. Generally, result in extensive blood loss;
2. Require major or prolonged invasion of body cavities;
3. Directly involve major blood vessels;
4. Are generally emergent or life-threatening in nature;
5. Commonly require systemic thrombolytic therapy;

Beginning January 1, 2026, CMS made these requirements optional rather than mandatory. CHA remains concerned that physicians may have a conflict of interest in selecting an ASC as the site of service when they own or have a financial stake in an ASC where the surgical procedure is performed. ASC services are not designated health services subject to the Stark self-referral provisions and CHA believes that CMS serves in an important quality oversight role by designating only those procedures that are safe to perform in an ASC. Once the above exclusion criteria are eliminated, patients could potentially have a procedure done in an ASC that is emergent or life-threating without any requirement to be informed that their life may be at risk when they are not in a hospital that will be better equipped to treat a patient in a life-threatening emergency.

CMS's proposal would add almost all procedures removed from the IPO list to the ASC CPL. The proposed rule does not provide any discussion to demonstrate that these procedures are safe and appropriate to provide in an ASC. The health and safety criteria that CMS has made optional were designed to not add highly invasive or risky procedures to the ASC CPL where the patient would be expected to need the specialized capabilities of a hospital. Absent having provided an analysis as to why these procedures are safe to perform in ASC, **CHA requests that CMS not finalize the addition of these procedures to the ASC CPL**.

- **Prior Authorization of Botulinum Toxin Injection Codes**

CMS proposes expanding prior authorization requirements to include additional botulinum toxin injection services. The specific codes are predominately medical in nature, not cosmetic. Botulinum toxin is a standard, evidence-based maintenance therapy for complex chronic conditions, including severe spasticity, cervical dystonia, chronic migraine, and neurogenic bladder dysfunction. Because these therapies rely on precise, repeated injection schedules—typically every 12 to 16 weeks—subjecting established patients to recurring prior authorization requirements will inevitably cause administrative delays and gaps in care. Unintended clinical consequences of these delays include severe symptom reemergence, loss of mobility, chronic pain, and preventable disease exacerbations that could drive avoidable emergency department visits or inpatient admissions. **CHA is concerned this proposal would create unnecessary barriers to care for patients who rely on these treatments and urges CMS to withdraw it.**

If CMS chooses to go forward, to prevent clinical harm it should establish streamlined renewal processes and exemptions from repeated PA requirements for patients whose diagnosis, clinical indication, and treatment regimen remain unchanged. If CMS seeks to manage service volume,

oversight should be narrowly targeted toward demonstrated areas of inappropriate utilization rather than applying blanket mandates.

- **National Provider Identification and Provider-Based Attestations**

Section 6225 of the CAA, 2026 prohibits Medicare payments under either the OPPS or the "applicable system" (40 percent of the OPPS for non-excepted off-campus provider-based departments) beginning January 1, 2028, unless an off-campus outpatient department of a provider bills using a separate National Provider Identifier (NPI) and the main provider has submitted an attestation that the department meets the provisions at 42 CFR §413.65. An initial attestation is required during the two-year period ending on the date such items and services are furnished. A subsequent attestation is required within a timeframe specified by the Secretary. The initial attestation can be submitted under the current 42 CFR §413.65 requirements until the Secretary establishes the new attestation process. The proposed rule provides information on CMS' implementation of the provider-based attestation requirements.

Under the current provider-based rules, any portion of the hospital that is not on the hospital's main campus is considered to be "off-campus" including a remote location of the hospital—a second campus that provides inpatient services. To be considered "on-campus," a provider-based department must be on the campus of the main provider or within 250 yards of the inpatient buildings of a remote location. CMS is proposing that a remote location will no longer be considered "off-campus" but instead be a secondary campus and a provider-based department will be "on-campus" if it is within 250 yards of the hospital's main campus or remote location. **CHA agrees with this proposal.**

With respect to attestations, CMS proposes to require initial attestations between January 1, 2026 and December 31, 2027 for services furnished before January 1, 2028 and within two years of the date of service for services furnished on or after January 1, 2028. Subsequent attestation(s) would be submitted at an interval to be specified by CMS in future rulemaking not to exceed five years. **CHA agrees with this proposal.**

There has been concern within the hospital community that the link between the initial attestation and the date of service could be interpreted as requiring an initial attestation every two years. However, CMS' proposal appears to require the initial attestation **one time only** either in the two-year period before January 1, 2028 for off-campus provider-based departments already in operation or before a new off-campus provider begins providing services on or after January 1, 2028. **CHA asks CMS to confirm that the initial attestation will only be required one time under its proposal.**

For a provider that has not received a provider-based determination, CMS proposes that the submission of the initial attestation will fulfill the CAA, 2026 attestation requirement to be paid under the OPPS or the applicable system. For a provider that has received a provider-based determination, CMS is considering having an authorized official attest using a letter with

evidence of the prior provider-based determination and affirming continued compliance with the provider-based rules without having to separately attest to meeting all the requirements of the provider-based rules. **CHA agrees with the first proposal and asks CMS to adopt the policy it is considering that an authorized official provides a letter demonstrating evidence of a prior provider-based determination and attestation of continuing to meet the provider-based rules.**

Under the current attestation process, providers submit their attestations and supporting documentation to their MAC, which performs a preliminary review and forwards its recommendation to CMS for the initial determination. CMS proposes to modify this process so that the MACs conduct standardized review and validation activities in support of initial determination rather than requiring separate CMS review of each attestation recommendation. **CHA agrees with this proposal.**

For providers that submit attestations for more than one off-campus outpatient department, CMS is considering streamlined supporting documentation requirements and seeks input on how best to minimize burden while ensuring robust oversight. Further, CMS anticipates leveraging system capabilities to reduce duplicative documentation submissions by allowing supporting documentation applicable to multiple locations to be submitted a single time, where appropriate. **CHA would welcome policies that minimize burden on hospitals by allowing them to submit a single attestation for multiple hospital sites seeking provider-based determinations**.

Finally, hospitals have had considerable concerns about the burden associated with section 6225 of the CAA, 2026 and it is unclear what policy concerns this statutory provision is intending to address. As the provision is statutory, we recognize that CMS is obligated to implement its provisions. As such, **CHA commends CMS for finding the least burdensome way to implement the required statutory provisions.**

- **2027 OPPS Hospital Price Transparency RFI**

Under the current hospital price transparency (HPT) regulations, hospitals are required to make public their standard charges in two ways: 1) In a comprehensive machine-readable file (MRF) format that displays all standard charges; and 2) In a consumer-friendly format. In a short span of time, a vast amount of hospital pricing information has been made available to the public. In an even shorter span of time, since the significant overhaul in the MRF formatting requirements in 2024, CMS has continued to make several significant and technically complex updates to the formatting requirements for these data, including in the CY 2026 OPPS final rule where the previously required "estimated allowed amount" was replaced by a new calculation of the median, 10th, and 90th percentile allowed amounts.[8] CMS issued additional guidance related to

[8] Federal Register: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots

display of certain contracting information in June of this year.[9] Each of these revisions imposes significant costs and burdens on hospitals, in particular, for small and rural hospitals, that unnecessarily diverts resources from patient care activities. Additionally, each revision increases the probability of hospitals falling short due to technical errors as demonstrated earlier this year when CMS issued over 500 warning notices to hospitals for such errors.[10] These unfortunate headlines serve only to perpetuate the myth that hospitals are persistently noncompliant while the reality is that hospitals are supportive of health care price transparency and work daily with patients in conjunction with their providers and payers to provide actionable pricing information in advance of providing a health care service.

Additionally, since CMS acted in 2019 to establish the HPT requirements, new and more appropriate tools have become available to provide individualized estimates to patients as part of both the hospital and insurer shoppable service requirements. Once the No Surprises Act is fully in effect, all patients will receive good faith estimates or advanced explanation of benefits prospectively. While these are "estimates" by definition, they are much more likely to produce usable and reliable cost expectations than the MRF data does because they are based on an individual's specific situation. Moreover, such estimates are considered part of the patient's medical record and are subject to a patient-provider dispute resolution process when the total billed charges are substantially more than the total expected charges in the good faith estimate. Thus, emphasis on the MRFs for consumers of health care services is misplaced.

Further, the data CMS requires payers to display under the Transparency in Coverage regulations (45 C.F.R. §§147.210–147.212) holds the greatest potential to provide the most comprehensive and actionable data for patients, employers, and other users because it requires disclosure of pricing information for all provider types, not just hospitals. Under these regulations, payers are also required to provide their members with consumer-friendly price comparison tools. CMS itself has recognized that disclosure of "standard charges" is "insufficient" by itself but is a "necessary and important first step" and has encouraged individuals to "avail themselves of hospital and payer price estimator and comparison tools, and to seek out 'good faith estimates' from hospitals."[11]

In the CY 2027 OPPS proposed rule, CMS seeks comment from the public on two main issues: 1) how to strengthen the transparency and usability of the data in MRFs with particular focus on the algorithms established in payer contracts for purposes of hospital reimbursement, and 2) how to improve the comparability of the data included in the consumer-friendly display to enhance consumers' ability to shop for care and obtain pricing information in advance of scheduled services.

[9] Hospital Price Transparency: Guidance on Encoding Outlier Contracting Clauses in a Hospital's Machine-Readable File
[10] White House warns 500+ hospitals to post price information or face fines: Report
[11] CY 2024 OPPS final rule (88 FR 82081)

CHA is generally supportive of price transparency, particularly when it provides patients with meaningful data to make decisions about their health care. However, the recent rapid regulatory shifts are burdensome and offer no clear benefit. CHA believes there are more appropriate avenues for ensuring consumers have the information they need prior to receiving health care services, including:

- Work collaboratively with CMS' Center for Consumer Information and Insurance Oversight (CCIIO) and the Departments of Labor and Treasury to better align the various current price transparency requirements to minimize confusing or conflicting information for patients.
- Leverage, potentially expand, and enforce the Transparency in Coverage requirements. Payers have visibility and control over provider reimbursement and allowed amounts, coverage determinations, and the individual's coinsurance requirements, progress towards meeting any applicable deductible, *et cetera*. Therefore, payers are the most appropriate party to report this information and inform consumers with health insurance coverage.
- Reduce hospital burden by removing the HPT consumer-friendly requirements at 45 C.F.R. §180.60 which are no longer necessary because of the passage and implementation of the No Surprises Act and Transparency in Coverage regulations. We understand that the HPT regulations were established at a time when there were no other options for consumers. However, since then, more targeted authorities are now available for CMS to ensure consumer access to meaningful pricing information.

Regarding CMS' RFI questions in this CY 2027 OPPS proposed rule, in general, CHA recommends the following:

- Take time to assess the impact of CMS' recently implemented requirements and guidance before revising the requirements again so soon. Hospitals incur great expense each time the regulations are revised, and adoption of the CMS guidance and new data elements, including the display of outlier provisions and the median, 10th, and 90th percentile allowed amounts only took effect over the past year, and as recently as April 1, 2026. This administration has made burden reduction a centerpiece of its agenda. Repeated changes to complex data transparency requirements are inconsistent with this goal.
- Recognize that the reimbursement mechanisms used by payers are so varied that standardization of payer algorithms is improbable. Additionally, since the median, 10th, and 90th percentile allowed amounts incorporate the algorithmic details necessary to generate a dollar amount that is applicable to the population of patients receiving the listed item/service, we do not believe standardization of algorithmic details is necessary at this time.
- If the 45 CFR §180.60 redundancy is not removed, retain the deeming clause to permit online price estimator tools rather than reverting to less useful flat files to display shoppable services. As noted above, CMS itself has acknowledged that online PE tools are more desirable than flat files for providing individualized price estimates, and it was

for this reason that CMS established the deeming policy. Recent research by the AHA has supported this finding.[12] We note that prior to implementation of the MRF format in 2024, CMS held a technical expert panel (TEP) and allowed for a period of time for hospitals to voluntarily adopt and test the MRF templates. CMS should engage with hospitals in a similar manner to explore options for improving upon the consumer-friendly displays.

- **Separate IPPS Payment: Personal Protective Equipment and Essential Medicines**

In this proposed rule, CMS discusses expanding the current voluntary payment policy under the IPPS and OPPS, under which CMS makes a payment adjustment to compensate hospitals for the additional resource costs that hospitals face in procuring domestic National Institute for Occupational Safety and Health (NIOSH)-approved surgical N95 filtering facepiece respirators (FFRs). CMS is seeking public comment on potential policy approaches for a payment adjustment, a methodology to calculate the price differential between domestic and non-domestic PPE and essential medicines, information sources of those price differentials, a definition of domestic essential medicine and PPE, and a process for verifying that a given essential medicine or PPE is "domestic."

CHA appreciates that CMS desires to support the purchase of domestically produced PPE. We ask that as CMS evaluates input from stakeholders on this issue, the agency develop an approach that supports this goal by reducing price barriers to purchasing domestically procedure PPE that does not involve overly burdensome administrative requirements for hospitals to receive the subsidy.

- **Request for Information on Advance Care Planning eCQM**

CMS seeks feedback on the potential inclusion in the Hospital Outpatient QRP of an Advance Care Planning eCQM and other quality measure concepts related to advance care planning. The agency specifically asks about application of the Advance Care Planning eCQM, which in the FY 2027 IPPS/LTCH PPS final rule was finalized for adoption in the inpatient setting for the Hospital Inpatient QRP, PPS-Exempt Cancer Hospital QRP, and Medicare Promoting Interoperability Program. The eCQM adopted for the inpatient setting calculates the proportion of adult patients with one or more inpatient hospitalization during the measurement period who, by the time of hospital discharge for at least one encounter, have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the patient's electronic health record (EHR). The measure has no exclusions. The consensus-based entity (CBE) has not yet endorsed the eCQM.

Our mission as Catholic health care providers calls us to serve a large population of vulnerable patients, including the senior population. Our members are committed to compassionately

[12] Fact Sheet: Price Estimator Tools | AHA

serving the elderly and chronically ill, including by providing holistic, person-centered care. **CHA commends CMS for its consideration of measure concepts that acknowledge the importance of advancing a person-centered process that aligns care with patient values and desires and dignity of life**. We believe health care is an ongoing conversation between patients and their care providers.

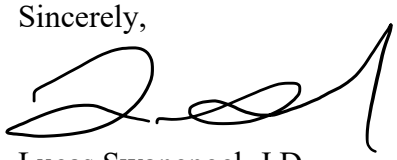
CHA strongly believes that measures adopted into the measure set should not detract from what is most important for the patient – time spent with the patient providing quality health care – and consequently have concerns with a measure that does not have any exclusions and has the potential to be overly burdensome. In considering application of measure concepts for advance care planning in quality reporting programs, we therefore **encourage CMS to limit such a measure to providers, settings, contexts, and patient populations that allow for appropriate opportunities to have the types of discussions needed to further meaningful acknowledgement and understanding of patient values and desires.** For example, typically providers with ongoing responsibility for managing a patient's care (such as the primary care setting) may provide a more meaningful opportunity than certain hospital outpatient contexts for having a discussion regarding advance care plans.

CHA also urges the agency to tailor any such measure for the Hospital Outpatient QRP specifically to the outpatient context in a manner that avoids duplication of efforts required by similar measures in other quality reporting programs. We encourage the agency's consideration of a measure that targets where there would otherwise be a meaningful gap in advancing person-centered care rather than a blanket application of a measure concept across all quality reporting programs. For example, we believe an advance care measure concept for the Hospital Outpatient QRP should complement (not duplicate) the MIPS Advance Care plan quality measure #047 applied under the Merit-based Incentive Payment System or the newly finalized eCQM for the Hospital Inpatient QRP, PPS-Exempt Cancer Hospital QRP, and Medicare Promoting Interoperability Program.

Finally, CHA continues to believe that only CBE-endorsed measures should be considered for inclusion in the measure set, and therefore **we believe that any measure considered for future adoption in the Hospital Outpatient QRP should be endorsed by the CBE**.

In closing, thank you for the opportunity to share these comments on the proposed 2027 OPPS proposed rule. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,



Lucas Swanepoel, J.D.
Vice President Public Policy and Advocacy