Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 15, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: **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 (CMS-1834-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) 2026 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment rates. This proposed rule updates OPPS payment policies that apply to outpatient services provided to Medicare beneficiaries; the hospital outpatient quality reporting program; reduces the OPPS update by 2 percentage points to recoup additional 340B spending, reduces payment for drug administration services furnished in off-campus provider-based departments (PBDs), eliminates the inpatient only (IPO) list, makes safety requirements in ASCs optional, announces plans for a drug cost survey in early 2026, modifies hospital transparency requirements and requires hospitals to report data on negotiated rates with Medicare Advantage Organizations (MAOs) that will be used as the basis of the inpatient hospital prospective payment system (IPPS) rates beginning in fiscal year (FY) 2029.

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

- **OPPS Update**

CMS is proposing to update hospital OPPS rates by 0.4 percent for CY 2026. This rate update equals the hospital market basket of 3.2 percent less 0.8 percentage points for total factor

productivity and an additional 2.0 percentage points to recoup additional spending on 340B acquired drugs.

The proposed 2.4 percent net market basket update (before the 340B adjustment) is inadequate and does not reflect the extraordinary inflationary pressures hospitals are facing and have faced over the past five years.

CHA reiterates its concern that upward pressure on hospital costs occurring throughout the pandemic has not been well represented in past year hospital market baskets, particularly for FY 2022, resulting in the update over three years for FYs 2021 through FY 2023 lagging by a combined 4.3 percentage points behind the rate of inflation.

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 2026 update upward accordingly so that hospitals are not permanently behind due to earlier missed inflation. **CHA requests that CMS adopt a forecast error correction policy for CY 2026 that accounts for three years of understatements of the market basket, totaling 4.3 percentage points.**

- **340B Repayment Acceleration**

Beginning in 2018, CMS adopted a policy to pay for drugs and biologicals acquired under the 340B program at average sales price (ASP) -22.5% rather than ASP +6%, the rate for separately payable drugs under the OPPS. Citing budget-neutrality requirements, this nearly 30% payment cut was offset by increasing payments for non-drug services to all hospitals paid under the OPPS by 3.19%. This policy was subsequently rejected by the United States Supreme Court in *American Hospital Association v. Becerra,* 142 S. Ct. 1896 (2022) as contrary to the Medicare statute. To comply with that decision CMS finalized a proposal to repay 340B hospitals in one-time lump sum payments totaling $10.6 billion. Again citing a need for budget neutrality, CMS also finalized a reduction to the OPPS conversion factor of 0.5 percentage points annually for 16 years beginning in CY 2026 until the full $7.8 billion in payments for non-drug services was recouped. CMS now proposes to recoup these additional payments over five years by increasing the reduction in the update from 0.5 to 2 percentage points. **CHA opposes this expedited timeline.**

CHA also reiterates its belief that application of budget neutrality to the repayment of wrongfully withheld 340B reimbursements is unwarranted and inappropriate. Hospitals should not be penalized for past actions taken by CMS, actions found to be inconsistent with the statute by the Supreme Court. Further, CHA questions whether CMS has the legal authority to apply this additional 2.0 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.[1] As CMS has already finalized an update of 2.6 percent for the FY 2026 IPPS, [2] CMS must apply the same update to the OPPS for CY 2026.

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 when it determines future payment levels based on past information but does not revise payment levels to adjust for subsequent events or information unless expressly authorized by Congress. This has been longstanding CMS policy in many contexts. As one example, 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.

However, CMS has been explicitly authorized to make prospective budget neutrality adjustments to recoup past increases in IPPS payments in the Tax Relief Act of 2012. CMS acknowledged overpayments that it could not recoup[3] until it received explicit authorization from Congress to adjust future payments to recoup past excess spending. CMS made recoupment adjustments for $11 billion in past IPPS spending due to documentation and coding from 2014 through 2017 as authorized by the Tax Relief Act.

As the current statute and longstanding policy do not allow CMS to make prospective adjustments to hospital rates to recoup past additional spending, **CHA reiterates its opposition to the application of budget neutrality here and opposes proposed expedited 2.0 percentage point annual reduction to recoup past additional spending for 340B acquired drugs**.

- **Notice of Intent to Conduct Medicare OPPS Drugs Acquisition Cost Survey**

Under section 1833(t)(14)(A)(iii) of the Act, CMS may either set payment rates for Part B drugs furnished in the hospital outpatient department based on a survey of hospital acquisition costs, or, if hospital acquisition costs are not available, default to paying ASP. CMS indicates its intent to do a drug acquisition cost survey for each separately payable drug acquired by all hospitals paid under the OPPS from January 1, 2026, through March 31, 2026. CMS intends to propose Part B drug payment policies based on this survey for setting 2027 OPPS rates, presumably to lower Medicare payments.

Although CMS indicates that hospitals have an obligation to respond to the survey, CMS is requesting comments on whether to make responding to the survey mandatory for all hospitals paid under the OPPS. CMS is also seeking comments on options for addressing non-response to the survey including:

[1] Section 1833(t)(3)(C)(iv) of the Social Security Act (the Act)
[2] 90 FR 37308.
[3] 78 FR page 50514.

- Using supplemental data sources such as the Federal Supply Schedule as non-respondent cost.
- Assume an ASP add-on percentage (0 percent, 6 percent or some other percent) as the hospital's cost.
- Assume that a non-respondent has insignificant drug costs and always package and never pay separately for the non-respondent's drug costs.

CHA urges CMS not to finalize the drug acquisition cost survey proposal. Requiring a survey at the level of detail that CMS proposes would place a significant burden on hospitals at a time when they are already facing significant financial and regulatory burdens.

CHA is also concerned by the options CMS presents for penalizing non-responders. There is no authority in section 1833(t)(14) of the Act or elsewhere that CHA could identify that would allow CMS to mandate participation, much less assume a percentage add-on for non-responding hospitals or assume that hospitals have insignificant drugs such that it would *never* be paid separately for drugs. Such a drastic penalty is neither authorized by statute nor warranted based on non-response to a survey. For such an enforcement action to be taken, CMS would have to be given explicit authority by statute.

Should CMS decide to go forward with its proposal, given the ongoing challenges that hospitals face due to staffing, it should proceed in a way that minimizes burden on providers**. Participation should be voluntary, consistent with this Administration's oft-stated goal of reducing administrative burden.** To ensure accuracy and comprehensiveness, CMS should use supplemental data sources and engage drug distributors and other entities involved in the supply chain to incorporate data points such as the cost of goods sold and any applicable discounts. Of the options above, CHA would support using the Federal Supply Schedule and other information as a mechanism of determining hospital costs for drugs**.**

- **Site Neutral Payment for Drug Administration Services**

Section 603 of the Bipartisan Budget Act (BBA) of 2015 provides that off-campus hospital outpatient departments (HOPDs) opened after November 2, 2015, are not to be paid under the OPPS but under another "applicable payment system" under Medicare Part B. CMS adopted the physician fee schedule (PFS) as the "applicable payment system" and set the reimbursement rate at 40% of the PFS rate. Congress specifically excepted from this new policy off-campus PBDs that existed prior to November 2, 2015, which Congress intended should continue to be paid under the OPPS (excepted HOPDs).

CMS now proposes to extend this site neutral payment policy to drug administration services delivered in excepted HOPDs in a non-budget neutral manner. CMS expresses concern about the growth of chemotherapy administration services, of nuclear cardiography services and of echocardiography services being performed in hospital outpatient departments, which it believes

is driven by financial incentives and therefore are unnecessary increases in the volume of OPD services and that this problem is pervasive and exists across service families. **CHA disagrees and strongly opposes expansion of site neutral payment to drug administration services in 2026**

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 from site neutral payment under section 603 of the Balanced Budget Act of 2015. By applying site neutral payment for drug administration 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." CMS' policy is not a "method;" it is a payment adjustment to one set of services code billed by grandfathered off-campus PBDs. 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 drug administration 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 drug administration services.

CMS Provides No Clinical Basis for Increased Utilization in Drug Administration being Unnecessary. CMS has not done any medical review or distinguished any characteristics of the patients to determine that treatment in the outpatient department is unnecessary. Many cancer patients are receiving these services, and it is highly possible that their medical condition or the toxicity of the drugs they are receiving necessitate treatment on an outpatient basis rather than in a physician office. Absent more detail on the specific condition of the patient, CHA does not believe CMS can conclude that drug administration services furnished in the outpatient department are unnecessary.

In future years, CMS plans to consider application of site neutral payment to other APC families of services, such as imaging without contrast, and other settings, specifically on-campus outpatient clinic visits. CMS is seeking comments on additional services furnished on-campus that could be also subject to site neutral payment methodology. CMS is also seeking feedback on

the development of a more systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity. **For the reasons above, CHA also opposes expanding site natural payment to additional services and to on-campus settings.**

- **Inpatient Only (IPO) List**

Services on the IPO list require inpatient care because of 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. The IPO list currently includes approximately 1,730 procedures and services which are not paid for as outpatient services. CMS annually reviews 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.

CMS finalized a proposal to eliminate the IPO in the CY 2021 OPPS final rule, then reversed course the following year restoring most of the codes that had been eliminated from the list in 2021. CMS now asserts that it believes that the evolving nature of the practice of medicine and advance in medical technology mitigates any potential patient safety and quality of care risks and that the setting of care should always be selected based on physician clinical judgment in consideration of a specific beneficiary's needs. Therefore, the agency proposes to eliminate the IPO list over three years beginning in 2026, completing the elimination by January 1, 2029. The IPO list would be eliminated in stages beginning with 285 musculoskeletal procedures and 16 non-musculoskeletal procedures. **CHA has significant concerns with ending the IPO.**

While we do believe physicians' clinical judgement should play a role in determining where patients receive care, we have concerns with the inconsistencies and barriers to care this proposal may create. To the extent that any of the procedures on the list may be safely performed in a hospital outpatient setting, CMS has an appropriate process and criteria to identify those procedures and remove them from the IPO. Many services on the IPO list are surgical procedures that can be complex and require high levels of care and coordinated services, such as invasive heart surgeries, organ transplants or amputations, for which the outpatient setting is not appropriate.

CHA is also concerned that the agency does not have the claims data necessary to appropriately determine how to place newly outpatient covered services into existing ambulatory payment codes (APCs) or create new APCs. While the proposed rule includes proposed APC assignments for 266 musculoskeletal-related services, CMS fails to provide any data or rationale for the proposed assignments. Further, given the breadth and timing of CMS' proposal to eliminate the IPO list over three years, determining appropriate payment for the volume of services would be a massive undertaking for the agency.

CHA urges CMS not to finalize the IPO list removal policy. Instead, CMS should continue with its standard process for removing procedures. It should also consider setting general criteria for procedure selection based upon peer-reviewed evidence, patient factors including age, co-morbidities, social support, and other factors relevant to positive patient outcomes to facilitate the appropriate removal of procedures from the IPO list.

Should CMS go forward with its proposal, CHA calls attention to CMS' statement that removal of a service from the IPO list has never meant that a beneficiary cannot receive the service as a hospital inpatient. CHA agrees with this statement and asks CMS to reiterate to MAOs its policy 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 outpatient does not mean that an MAO can require all patients to be treated outpatient.

Two-Midnight Rule

Under the two-midnight rule, an inpatient admission is considered reasonable and necessary when the physician expects the patient to require a stay that crosses at least two midnights with case-by-case exceptions allowed under certain circumstances. Procedures on the IPO list are appropriate for inpatient hospital admission regardless of the expected length of stay.

Consistent with its prior policy to eliminate the IPO list, CMS is proposing to indefinitely exempt procedures removed from the IPO list from site-of-service claim denials under Medicare Part A, eligibility for initial medical review contractor referrals to Recovery Audit Contractors (RACs), and RAC reviews for "patient status" (that is, site-of-service) until such time as the procedure is performed 50 percent or more of the time in an outpatient department. If CMS finalizes its proposal to eliminate the IPO list, CHA urges it to also finalize the proposed indefinite exemption of the removed procedures from the medical review activities. CMS should use notice and comment rulemaking, not sub-regulatory guidance as proposed, to end exemption periods and include the quality and patient safety data it relied on to determine that a procedure can be safely performed in the outpatient setting.

- **Making Ambulatory Surgical Center Health and Safety Requirements Optional**

Under the current regulations (42 CFR 416.166), surgical procedures are appropriate for inclusion on the ASC list when the procedure would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure. There are currently eight criteria which, if applicable, exclude a procedure from being performed in an ASC. CMS is proposing to move five of these criteria into a new section and treat them as non-binding physician considerations for patient safety. Under this new policy, physicians would then assess whether their specific patients can or cannot safely receive such covered surgical procedure in the ASC setting based on patient-specific considerations.

CMS also proposes to update the ASC list by adding 276 potential surgery or surgery-like codes to the list that the agency believes would meet the proposed revised ASC list criteria under new §416.166(b)(2).

CHA opposes CMS' proposal to eliminate the ASC exclusion criteria that are necessary to protect patients from having procedures performed in an ASC that are unsafe to perform in that setting. While CMS believes that the ASC conditions for coverage provide assurance that services furnished in the ASC setting are held to a high standard of safety, CHA remains concerned that finalizing this proposal would result in far more and higher-risk surgical procedures being covered in ASCs in a manner that could negatively impact Medicare beneficiary safety and quality of care. ASC services are not designated health services subject to the Stark self-referral provisions and CHA believes that CMS serves 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 situation. Furthermore, beneficiaries may also unexpectedly face higher out-of-pocket costs for surgeries performed in an ASC than in an HOPD. This is because the beneficiary copayment for services provided in an HOPD is capped at the inpatient deductible amount, while the same is not true for services provided in an ASC.

We further note that ASCs are intended to be for scheduled, ambulatory surgical procedures. Among the 276 procedures that CMS proposes to add to the ASC list are many procedures that are not surgical procedures or are procedures that would never be scheduled such as:

- Several pheresis procedures that are not surgical procedures at all that would be covered when performed in an ASC even though an ASC is specifically for surgical procedures.
- CPT code 37195 is for administration of a thrombolytic agent intravenously to treat cerebrovascular occlusion, commonly associated with stroke treatment. A stroke is a medical emergency. Patients do not have a stroke treated on a scheduled basis in an ASC. A stroke is a medical emergency that requires treatment in hospital. CPT code 37195 should not be an ASC list procedure.
- There are several procedure codes for exploration of a penetrating wound (often billed when the patient has a gunshot or a stab wound). There are many other procedures that treat a trauma that are not likely to be scheduled and should not be eligible to be done in the ASC.

Inclusion of these procedures on the ASC covered procedures list seems highly inappropriate and suggests that more work needs to be done to identify procedures that can be appropriately performed in an ASC. **CHA opposes CMS' elimination of health and safety requirements for ASCs and its proposal to add 276 procedures to the ASC list**.

- **Virtual Direct Supervision of Certain Hospital Outpatient Services**

CMS is proposing to extend virtual supervision (excluding audio only) of Cardiac Rehabilitation, Intensive Cardiac Rehabilitatin, and Pulmonary Rehabilitatin and diagnostic services under the PFS permanently in the 2026 PFS proposed rule except for services with a 10 or 90-day global period. In the 2026 OPPS proposed rule, CMS is proposing to extend virtual supervision (excluding audio only) under the OPPS permanently for these same services. **CHA supports this proposal.**

- **Hospital Transparency Data**

CMS proposes several changes to the hospital price transparency requirements. First, CMS proposes requiring several new data elements in instances when payer-specific negotiated charges are based on a percentage or algorithm. CMS also proposes requiring a specific methodology, including a set lookback period, and the use of electronic data interchange 835 electronic remittance advice transaction data to calculate these values. These values would replace the "estimated allowed amount" value that was added in the final CY 2024 OPPS/ASC rule. The proposed rule would also update the required affirmation statement that hospitals must attest to in their machine-readable files.

CHA supports price transparency policies that empower patients by providing them with clear, accurate and meaningful data to make decisions about their healthcare. **However, CHA recommends CMS not finalize its proposal which risks misleading and overwhelming patients while imposing significant administrative burdens on hospitals, contrary to the Administration's focus on reducing unnecessary regulation.**

Under the current hospital price transparency (HPT) regulations, hospitals are required to make public their standard charges in a comprehensive machine-readable file (MRF) format that displays all standard charges and 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. Most recently, hospitals implemented new technically complex requirements because of CMS' revision requiring hospitals to adopt a standardized template format and to make public additional data elements available in the MRF, including an "estimated allowed amount" which was implemented as recently as January 1, 2025. CMS issued additional guidance related to implementation of the "estimated allowed amount" May of this year. Each of these revisions imposes significant costs and burdens on hospitals.

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 healthcare 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. This rule, however, has not been amended since originally promulgated and CMS has not made public any data about enforcement activity and industry compliance.

The vast amounts of data presented in the MRF format and hospital "standard charges" are not consumer friendly and do not provide patients with the personalized prospective information they need to make informed decisions. CHA believes CMS should instead work collaboratively with the Departments of Labor and Treasury to better align the various current price transparency requirements to minimize confusing or conflicting information for patients. More can be done to leverage 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, etc. Therefore, payers are the most appropriate party to report this information. In addition, the HPT regulations were established at a time when there were no other options for consumers. They are no longer necessary given the No Surprises Act and Transparency in Coverage regulations

Should CMS go forward with its proposal, the implementation timeline should be extended. The proposed January 1, 2026, implementation date does not provide hospitals with enough time to produce their data in a revised CMS template format and to calculate new data elements (10^{th}, median, and 90^{th} percentile allowed amounts) from 835 remittance advice data. Once the new CMS template and updated validator tool are available, hospitals will need at least 6-12 months to calculate, encode, validate, and display the data. More time will be required if a hospital, because of the new requirements, must hire new staff or a vendor that can perform the proposed calculations for the 10^{th}, median, and 90^{th} percentile allowed amounts.

We also offer comments on specific aspects of the proposal.

Replacing the "estimated allowed amount" with the 10^{th}, median, and 90^{th} percentile allowed amounts: CHA recommends that CMS maintain its current requirement for hospitals to calculate and disclose the "estimated allowed amount" using the data available to the hospital. Hospitals have just revised their systems to accommodate the new requirement to display the "estimated allowed amount." We question why CMS believes that the "estimated allowed amount" is less valuable or insufficient to achieve its goals of bringing more meaning to hospital standard charges when such charges can only be expressed as an algorithm or percentage. Changing the

requirements now would markedly increase hospital burden without any clear benefit to the public. Again, this proposal is inconsistent with the Administration's burden reduction initiatives.

Requiring hospitals to exclusively use EDI 835 electronic remittance advice data using a one-year lookback period for calculating the 10th, median, and 90th percentile allowed amounts: We have several concerns. First, not all providers receive remittance advice from payers in electronic form.[4] Second, even if CMS were to permit hospitals to use both electronic and paper remittance advice data for calculation of the 10th, median, and 90th percentile allowed amounts, a one-year lookback may not be enough to accumulate an adequate or meaningful count for a payer's plan with which the hospital has recently negotiated or renegotiated a contract. Continuing to permit hospitals to calculate and display an "estimated allowed amount" using all the data available to the hospital sidesteps this problem and results in a more meaningful dollar value. Therefore, **CHA recommends that CMS not finalize its proposal to require hospitals to use exclusively EDI 835 electronic remittance advice data**. Instead, CHS recommends that CMS retain the current requirements to use any available data in calculating and displaying the "estimated allowed amount". If CMS finalizes its policy as proposed, we recommend that CMS allow hospitals to leave the 10th, median, and 90th percentile allowed amounts blank when the EDI 835 ERA data count is "less than 10" to align with CMS' guidance and best practices for making claims data public.

Replacing the currently required good faith affirmation statement with an attestation: CHA **opposes this proposal for several reasons**. First, by removing the phrase "to the best of its knowledge and belief," the proposed revised language no longer leaves room for human error which is necessary when handling (in many cases, manually) millions of datapoints. The language also appears to expect that the hospital executive named in the file (and who would now be required to make the attestation) has personally verified each data point. CHA believes this is an unreasonable expectation, as hospital executives are likely to rely on staff review and confirmation of the data, rather than validating millions of data points personally.

Second, the phrase "has provided all necessary information available to the hospital for the public to be able to derive the dollar amount" is too broad. This language appears to assume that members of the public 1) are capable of prospectively anticipating their every need during an episode of care; and 2) have the specialized knowledge and understanding of processes and nuances that underlie hospital billing, coding, and reimbursement, some of which may or may not be included in the contractual algorithm. Moreover, some contractual algorithms consider so many individualized dependencies, they do not lend themselves easily to being displayed in a single cell in an MRF.

[4] CMS' guidance (Remittance Advice Resources and FAQs) acknowledges that some providers receive this information on paper.

Third, the proposed attestation refers to "standard charge information" as did the affirmation currently in place, which is inclusive of all data in the MRF. We note, however, that CMS is proposing to replace the "estimated allowed amount" (which currently gives a hospital flexibility to choose the best data available to it) with the 10th, median, and 90th percentile allowed amounts based exclusively on EDI 835 ERA data (which are exclusively developed by the payer). In other words, hospitals do not have control over the accuracy and completeness of EDI 835 ERA data and would therefore not be able to make the attestation as proposed. For all these reasons, **CHA recommends that CMS retain the affirmation statement in its current form**.

Reducing CMPs upon waiver of a hearing: **CHA is generally supportive of CMS' proposal to reduce the amount of a CMP by 35 percent should a hospital submit to CMS a written notice requesting to waive its right to a hearing** under §180.100 within 30 calendar days of the date of the notice of imposition of the CMP. However, we have noticed that smaller hospitals appear more likely to receive a CMP notice from CMS.[5] CHA therefore encourages CMS to continue providing hospitals with robust technical assistance and sufficient opportunities to correct deficiencies prior to issuance of a CMP.

- **Market-Based Relative Weights**

CMS proposes to require hospitals to report market-based payment rate data focusing on median of payer-specific negotiated charges. Hospitals would be required to report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) plans, by MS-DRG. CMS expects this data to be used as the basis for the hospital inpatient PPS relative weights in FY 2029**.** CMS believes this policy will reduce reliance on hospital chargemasters and inject more market pricing into Medicare payment rates. **CHA opposes this proposal and urges its withdrawal.**

In the proposed rule, CMS highlights its concerns that hospital chargemasters do not reflect true market costs. CMS presumes that MA and commercial rates reflect competitive negotiations between hospitals and commercial plans, including MA. While this may be the case for some markets and individual hospitals, other factors may contribute to the rates paid by MA plans and private insurers, including whether rates are set based on Medicare fee-for-service or the level of competition (between either hospitals or payors) in the individual hospital's market.

Many MA-specific rates are set based on Medicare fee-for-service and therefore are reflective of the existing MS-DRGs. The competitive market forces are limited to the percentage of the IPPS rate being paid (e.g. some percentage above or below the IPPS rate with the MS-DRG being used as a convenience mechanism for determining the distribution of payments among the MA patients the hospitals will treat).

[5] As evidenced by CMS' most recent issuance of CMP notices in 2025 in which the penalized hospital bed count ranged from "less than 30" to 140 with a median of 35.5 beds. Enforcement Actions | CMS

In the preamble of the regulation, CMS notes that its "research suggests that payer-specific charges negotiated between hospitals and MA organizations are generally well-correlated with Medicare IPPS payment rates." If that is the case, there would be no point in adopting MA rates in place of the current relative weight system as it would lead to little or no change in the final rates but would impose significant burden on hospitals.

Even for those plans that do set rates independent of the IPPS rates, the plans are still limited by Medicare fee-for-service regulations and MA-specific policies set by the government. For the reasons noted above, it is unlikely that setting rates based on charges negotiated by MA plans would result in true market-based rates at the MS-DRG level that are any different than they are now.

Without insight into whether commercial rates are reflective of true market-based negotiations at the MS-DRG level, CMS is committing itself to a new metric that could be less accurate than its current methodology while imposing new significant burdens at hospitals—again at odds with the Administration's goal of reducing administrative burden in healthcare. Section 1886(d)(4)(B) requires that the Secretary establish MS-DRG weights that reflect the relative hospital resources within a DRG relative to the average across all DRGs. As detailed below, we are concerned that use of median negotiated MA rates may introduce new distortions into the MS-DRG methodology that will result in weights that no longer reflect the resources required to furnish care to the Medicare population.

CMS acknowledges that not all payer-specific rates will be based on MS-DRGs. For example, some hospitals may negotiate rates on a per diem basis. As a result, hospitals will have to use their own discretion to crosswalk these other rate-setting mechanisms to MS-DRGs, which may not always be feasible. In doing so, hospitals may apply different methodologies, which may not reflect the true cost of care in these hospitals and may introduce new distortions into the rate-setting process.

Additionally, since non-MA commercial plans typically serve a different demographic than the general Medicare population, commercial rates may not be truly reflective of the resource utilization needed to care for Medicare beneficiaries, who often have higher complications and comorbidities than the general population. Given that MS-DRG weights are set in a budget neutral manner, this proposal may have the effect of shifting payments in a less informed and less precise manner.

Finally, CMS states that it expects its proposal will pose minimal burden because hospitals could utilize data they are required to report under the Hospital Price Transparency rule to calculate the median negotiated charges. CMS estimates that this proposal will create an average annual burden of 20 hours per hospital. CMS grossly underestimates the amount of time it will take hospitals to calculate and report median rates by MS-DRG.

The current proposal requires hospitals to report median negotiated rates based on MS-DRG, whereas hospitals are required to publicly report standard charges under the Hospital Price Transparency regulation. As a result, hospitals will likely need to calculate the median based on additional information or to go through a manual process of calculating MS-DRGs based on the price transparency data.

Additionally, as CMS notes in the preamble, some third-party payers do not pay based on MS-DRGs. As a result, hospitals will need to calculate an MS-DRG based on the same or similar package of services. This process becomes even more complicated if commercial plans do not pay the hospital based on fee-for-service rates. As a result, this proposal places significantly higher burden on hospitals than is reported in the proposed rule. We urge CMS to revise this estimate and to take this into consideration when assessing this proposal and again consider whether this proposal is consistent with the Administration's goals to reduce burden on health care.

- **Quality Programs**

Cross-Program Proposals to Remove Measures from the HOQR, REHQR, and ASCQR Programs

CMS is proposing several measure removals for the Hospital Outpatient, Rural Emergency Hospital and Ambulatory Surgical Center Reporting Programs (HOQR, REHQR, and ASCQR respectively): the COVID-19 Vaccination Coverage among Healthcare Personnel measure (HOQR, ASCQR), the Hospital Commitment to Health Equity (HCHE) (HOQR and REHQR), the Facility Commitment to Health Equity (FCHE) (ASCQR). CMS proposes to remove from all three quality programs, the Screening for Social Drivers of Health (SDOH-1), and Screen Positive Rate for Social Drivers of Health (SDOH-2) measures.

CHA supports removal of the Covid-19 measure. However, we urge CMS not to remove the HCHE /FCHE measures and two SDOH measures.

The goal of the HCHE/FCHE measures (as applicable) is to identity and address health disparities – that is, to collect and use data to see if any particular populations routinely have poorer health outcomes and to try to understand and address the underlying causes. To that end the measures ask facilities to attest to their commitment to health equity across five domains: Strategic Priority, Data Collection, Data Analysis, Quality Improvement, and Leadership Engagement. The SDOH measures ask hospitals and facilities to collect data essential to understanding the health needs of their patients and to identify factors that contribute to health disparities. Hospitals and facilities are to seek information from all admitted adult patients about five health related social needs (HRSNs), food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety, and to calculate positivity rates for each HRSN among the screened population.

CHA and its members are firmly committed to providing holistic and compassionate care to all patients, including by providing attention to their health-related social needs, and we endorse the value and importance of screening for such needs. Indeed, many of CHA's members have been

pioneers and leaders in the screening and collection of SDOH data from their patients and working with community partners to ensure patients have access to resources to address their needs. While we supported the screening measures when they were proposed, we did express the concern that the measures alone would not necessarily promote linkages with relevant community-based services that would address those needs and support improvements in health outcomes following hospitalization. We continue to believe that screening for social needs, when done in an appropriate manner and part of a larger community-wide system to provide the services needed, is a valuable goal that should be encouraged and supported. Indeed, screening for social needs could result in long-term savings through improved chronic disease management, which is also consistent with the goals of the Make America Health Again initiative.

CHA believes that the HCHE/FCHE measures as well as the two SDOH measures serve a role in improving care for vulnerable populations and are concerned that the removal of such measures could impede the progress that is being made in closing gaps in care - and could in fact increase such gaps. Consistent with our comments submitted regarding similar proposals for the Hospital Inpatient Quality Reporting (HIQR) Program, we recommend that rather than ending the current measures CMS should work with stakeholders to develop technical support and education in the most effective way to both screen for social needs and work with community and other organizations to meet those needs. This would help to address the concerns raised by the agency regarding the administrative costs of continuing the use of the measures, while recognizing the value that the measures contribute to providing compassionate and holistic care.

If CMS finalizes its proposal to remove the HCHE, FCHE, and two SDOH measures, we urge CMS to engage stakeholders on alternative strategies to identify and address health disparities, including ways to help patients with health-related social needs to connect with community partners who can help them meet those needs.

Cross-Program Proposal to Make Updates to Extraordinary Circumstances Exception Policies

CMS is proposing updates to the Extraordinary Circumstances Exception (ECE) policy under the HOQR, REHQR, and ASCQR Programs. The ECE policy allows for exceptions to data reporting requirements under extraordinary circumstances, such as natural disasters or systemic problems with CMS data collection systems that directly affect facilities' ability to submit data. CMS is proposing that it would grant reporting deadline extensions, as well as exceptions, as it would find appropriate. An extraordinary circumstance would be defined as an event beyond the control of the hospital. The agency is also proposing a hospital would have to request an ECE within 30 calendar days from the event, a change from the current policy which allows requests to be submitted within a 90-day window. In the FY 2026 IPPS/LTCH final rule, similar ECE proposals were finalized, with modification, for several quality reporting programs.

CHA and our members support the availability of ECE policies under the quality programs. Our members rely on and appreciate the availability of an ECE when events beyond the control of a hospital impede a hospital's ability to comply with the requirements of a quality program. **We**

support the proposal to provide an additional form of an ECE in the form of an extension to a deadline to allow a hospital or other facility additional time to comply with a requirement.

However, CHA opposes reducing the period during which a hospital may request an ECE from 90 days to 30 days from the date of the extraordinary circumstance. ECEs are by definition granted for unforeseen events, such as natural disasters, which can affect performance metrics and the ability of hospitals to comply with reporting and other requirements. In these circumstances 30 days is often not sufficient time to respond effectively to the extraordinary event (a hospital's immediate concern), assess the effect on data collection and systems, and submit a request for an ECE. Reducing that period from 90 to 30 days is a substantial shortening of the submission period that will impose additional burden and harm on hospitals struggling to address a crisis and in most need of administrative flexibility. We urge CMS to maintain the current 90-day window.

If CMS finalizes shortening the ECE submission period, we recommend the agency consider a period that is not shorter than 60 days. Specifically, CMS could align the ECE submission period under these three quality programs with the ECE submission periods recently finalized for quality programs in the FY 2026 IPPS/LTCH final rule. In that final rule, CMS finalized modified proposals, which changed the proposed 30-day window to a 60-day window, to address many concerns raised with shortening the ECE request window. While maintaining the current 90-day timeframe would be preferred to provide the needed flexibility, we would at least request that CMS align the ECE request window for the HOQR, ASCQR, and EHQR Programs with the 60-day timeframes finalized for the quality programs in the FY 2026 IPPS/LTCH PPS final rule.

Request for Information on Future Measure Concepts of Well-Being and Nutrition

CMS issues a request for information on future measure concepts for the HOQR, REHQR, and ASCQR Programs, specifically on measures to address well-being and nutrition.

CHA supports the general goals of pursuing a comprehensive approach to disease prevention and health promotion, especially an approach that is person-centered. Overall, we believe that, as guiding principles, quality measures should be applicable to the specific setting, have utility, give actionable feedback, be data-driven, based on well-documented outcomes, and feasible. We also continue to believe that measures included in the CMS quality programs should be endorsed by the CBE. While we support the concepts of well-being and nutrition, we are concerned that these concepts are amorphous and vague and may be difficult to clearly define and measure. We encourage that clear definitions and scopes that are specific and applicable to the outpatient setting be specified for any such measure and that the agency ensures the information received from such a measure be informative to the specific outpatient setting and within the control of the hospital or facility to act upon.

Proposals to Adopt the Emergency Care Access & Timeliness eCQM into the HOQR Program Measure Set and the REHQR Program Measure Set

CMS is proposing to adopt into the HOQR Program measure set the Emergency Care Access & Timeliness eCQM beginning with voluntary reporting for the first year and mandatory reporting

thereafter. This measure considers (i) patient wait time longer than one hour, (ii) patient left the ED without being evaluated, (iii) patient boarding time in the ED longer than four hours, and (iv) patient ED length of stay longer than eight hours. It would replace two current chart-based measures. In addition, CMS is proposing to adopt the measure into the REHQR Program measure set as an optional alternative to reporting the Median Time for Discharged ED Patients measure If finalized, the Emergency Care Access & Timeliness eCQM would be the first eCQM in the REHQR Program.

CHA appreciates CMS' goal of reducing administrative burden and providing more comprehensive data by replacing the two chart-based measures with the eCQM. We believe it prudent, however, to consider unintended consequences, such as the concerns raised by the PRMR Hospital Recommendation Group that the measure may cause an increase in cost of care due to patients being transferred from the ED to observation. CHA very much appreciates CMS' proposal to initially adopt the eCQM in the HOQR Program with voluntary reporting. However, we urge the agency to extend the one-year period of voluntary reporting to allow hospitals additional time to train staff and make necessary adaptations to their EHR systems as well as for CMS to collect sufficient data to determine the extent to which there may be any unintended consequences. The consensus-based entity (CBE) endorsed the eCQM with conditions for use in the HOQR Program, including to allow the measure developer to explore unintended consequences to patients and hospitals and data elements to identify and address where challenges persist. Extending the voluntary period would permit hospitals and the agency the time needed to take into account any additional findings or data elements identified by the measure developer pursuant to the CBE condition.

In addition, CHA appreciates the proposal to include the eCQM as an optional alternative measure under the REHQR Program. We believe it is essential that policies and measures adopted for the REHQR Program are appropriate and relevant to the REH context. We continue to recommend that the measure set includes measures that have been successfully reported by most CAHs in the past. We also caution that the REHQR program should be especially attentive to avoiding the imposition of time and cost burdens on these facilities, which have limited resources and are still in their start-up phase. If this eCQM is adopted into the REHQR Program measure set it should be, as proposed, an optional alternative measure to the Median Time for Discharged ED Patients measure, and not a required measure.

Proposal to Modify the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level-Outpatient) measure (Excessive Radiation eCQM)

CMS is proposing to modify the Excessive Radiation eCQM in the HOQR Program measure set by extending the voluntary reporting of the measure. Instead of mandatory reporting beginning with the 2027 reporting period, the eCQM would remain voluntary indefinitely.

CHA supports the modification to extend voluntary reporting so that HOPDs could gain further experience with the eCQM.

Hospital Quality Star Rating: Safety of Care Measure Group Proposal

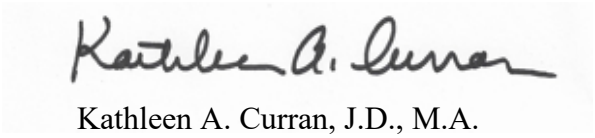
CMS is proposing to modify the Overall Hospital Quality Star Rating methodology in a two-step process by first implementing a four-star cap for hospitals in the lowest-performing quartile of the Safety of Care measure group for the 2026 Overall Hospital Quality Star Rating, and then for the 2027 star ratings and for subsequent years (instead of the 2026 cap) by implementing a one-star reduction for hospitals in the lowest-performing quartile of that measure group.

CHA commends CMS on its continued efforts to improve patient and health care workforce safety and address safety gaps in health care delivery. Patient and workforce safety is integral to our members' commitment to providing compassionate, high-quality care in a safe, protected environment. We strongly support initiatives that emphasize and effectively advance safety of care at hospitals and that support hospitals in achieving high standards of safety of care. We encourage the agency to pursue a methodology that emphasizes such goals. However, we also acknowledge the value of the other quality measure groups that are part of the Overall Hospital Quality Star Rating and the value of quality measures in the other groups of measures as well.

In addition, CHA encourages that before implementing the proposed methodology change, CMS ensure that all quality measures included in the Safety of Care measure group are informative for representing the experience of patient and workforce safety at hospitals and are actionable. We encourage the agency to further its efforts in support of patient and health care workforce safety and efforts that will effectively produce improvements in care safety, including by furthering initiatives that provide hospitals with the data to identify any gaps in such care and the tools to address such gaps. **To that end, CHA encourages CMS to conduct further testing so there is ample opportunity to correct for unintended consequences before public reporting begins.** In addition, we request further information on how and when hospitals will receive information on whether they are in (or are expected to be in) the lowest-performing quartile of the Safety of Care measure group so that there is opportunity for a hospital to act and make improvements.

In closing, thank you for the opportunity to share these comments on the proposed 2026 OPPS proposed rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me at 202-721-6300.

Sincerely,



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