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The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1834-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz:

On behalf of the Alliance of Safety-Net Hospitals, we appreciate the opportunity to provide feedback in response to the Centers for Medicare & Medicaid Services (CMS) CY 2026 outpatient prospective payment system (OPPS) proposed rule published in the *Federal Register* on July 17, 2025.

The Alliance of Safety-Net Hospitals (ASH) represents a network of hospitals and health care providers dedicated to helping American families stay healthy, working, and independent. Our members are committed to delivering strong, reliable care that families can count on when it matters most. We play a critical role in the health care system, providing essential services to those who rely on Medicare, Medicaid and other public programs for access to care.

In this letter, we present our comments on the following aspects of the proposed rule:

- Proposed rate update
- 340B Repayment Acceleration
- Volume Control Policy for Medication Administration
- Elimination of the Inpatient Only List
- Hospital Price Transparency
- Quality Reporting Program Proposals

Proposed Rate Update

CMS proposed an outpatient rate increase of 2.4 percent in CY 2026. ASH appreciates this proposed increase, but we are disappointed to see that the calculated market basket has again failed to keep pace with the financial reality facing hospitals and outpatient hospital clinics.

We join other hospital stakeholders in once again urging CMS to reconsider its data source for workforce costs considering how the health care industry staffing model has shifted since the pandemic and workers have demanded higher salaries to keep up with economic changes. The ECI survey of hospital employment

costs that CMS employs only includes employed hospital staff, not contracted or contingent workers. The increased use of contracted staff that was sparked by the pandemic has proven not to be transitory and the rate calculation methodology needs to recognize these costs to keep up with hospital needs and patient access to outpatient services.

Unfortunately, even the modest proposed 2.4 percent increase will remain out of reach for hospitals if the two other proposals included in this rule are finalized: the 340B repayment acceleration and the volume control policy for medication administration services.

340B Repayment Acceleration

After courts rejected CMS's previous plan to reduce payments to covered entities for 340B covered drugs, the administration was ordered to make affected hospitals whole with lump sum payments in 2024. To rebalance the OPPS budget, the agency issued an interim final rule in September 2024 that finalized a plan to reduce the outpatient conversion factor by 0.5 percent each year for 16 years. In this proposed rule, CMS now seeks to accelerate those reductions with annual decreases of 2 percent for almost all hospitals over the next six years. We urge CMS to reconsider this plan.

Since the 340B litigation concluded in 2023, hospitals have been planning for the 0.5 percent reductions, but this sudden change was never expected. A sharp increase like the one proposed is not something any hospital budget could have planned for and it is certainly not something that safety-net hospitals can shoulder for 2026 and the following five years without making substantial cuts to their services. Safety-net hospitals rely heavily on government payer sources which do not cover costs and this gives them little room to supplement from other revenue sources. Like all hospitals, they also need to be ready to address future shifts in care patterns that will soon present them with older, sicker populations with more complex, chronic conditions that are more costly to care for.

ASH understands the desire to reconcile past financial outlays as soon as possible, but hospitals are simply not in a position to shoulder a 2 percent reduction over the next six years. Recent estimates from the Congressional Budget Office predict a new 4 percent Medicare sequestration to begin in January 2026 unless Congress acts to mitigate that impact. With the proposed 340B repayment policy, that would mean all outpatient hospital services would be cut as much as 8 percent next year and no industry – health care or otherwise – can weather such a large decrease without also decreasing patient services and making workforce changes.

Certainly, we do not support the alternatives that CMS stated in the rule, such as demanding repayment from each affected hospital in one-time checks, but there are more options available under the court's order that CMS did not describe in the rule or provide reason for not pursuing them. For example, CMS could incrementally increase the 340B repayment percentage to shorten the overall repayment period but do so in a way that accommodates other financial pressures in the industry. In such a scenario, the CY 2026 withhold can remain at 0.5 percent since there are other planned cuts for Medicare providers because of sequestration, and CMS can plan to move to 0.75 and then 1 percent in future years – if those sequester cuts are mitigated by Congress.

340B Hospital Survey

We understand that CMS will soon be launching a survey of covered entities to gather information on the acquisition costs for each separately payable drug acquired by all hospitals paid under the OPPS and the agency plans to use that information to propose a new 340B payment policy in the CY 2027 proposed rule. ASH supports policies that are built on valid data and we support the collection of survey data, however we

caution CMS against making abrupt changes to the 340B payment policy as soon as CY 2027. We commit to providing the best available data through this survey, but we hope that CMS will carefully consider data validation and analysis not only to craft payment policy but to estimate the economic impact of changes to 340B payment policies prior to proposing them in CY 2027. It is difficult to see how such a quick turnaround can produce reliable results.

Hasty and inaccurate data collection could lead CMS toward reimbursement policies that will directly impact Medicare beneficiaries rather than correct any perceived inequities in hospital reimbursement. The 340B program was created by Congress to help improve access to high-cost prescription drugs for patients by giving high-Medicaid hospitals the tools to stretch scarce resources. In hardworking communities, these public payor hospitals are empowered by 340B payment policies to provide care that their patients might otherwise not be able to afford and offer services that might otherwise be unavailable in that area. Any change in 340B savings to these community hospitals will jeopardize this important work.

Congress has not directed the executive branch to reduce payments to 340B providers and did not direct CMS to introduce new policies that seek to reduce the federal government's commitment to serving low-income Americans. We urge caution for CMS's next steps to survey 340B providers and parse that survey data to inform future reimbursement policies. Without a demonstrated need or a directive from Congress, we do not believe now is the appropriate time to take resources out of the hands of community hospitals.

Volume Control Methodology

CMS proposed a new payment policy for medication administration services that would reimburse outpatient departments at the physician fee schedule (PFS)-equivalent rate when these services are provided at an off-campus provider-based department (PBD) that is excepted from 1833(t)(21) of the Social Security Act. To support this change, CMS points out its authority to control unnecessary increases in the volume of services in the OPPS, but we do believe this change in volume has been made necessary by a lack of community-based infusion options. Financial incentives have not driven the increase in hospital-based primary care clinics, particularly in striving communities served by community safety-net hospitals, and they are especially not to blame for the increase in infusion services provided in these clinics. We urge CMS to abandon this proposal.

Hospitals Serve Primary Care Role

In so many parts of the country, and especially in urban areas that are home to working poor families, hospitals are the main or the only source of primary care for the American community. Individuals rely on hospitals and hospital-based outpatient clinics to meet their preventative care needs like testing and to help them manage their chronic conditions. This reliance puts pressure on hospitals to maintain access to primary care and sometimes that means the hospital acquires a primary care office rather than having those physicians shutter their doors. These acquisitions are not primarily motivated by the Medicare reimbursement differential between OPPS and PFS payment rates, as CMS states in the proposed rule. If PBDs were not an option, some populations would not have the option for outpatient primary care. Individuals would be left to use the emergency department to meet their needs – or worse – allow those needs to become so acute that they need inpatient treatment.

In addition to providing primary care through PBDs, hospital outpatient volume growth can be attributed to other factors that are not financial in nature:

- The Hospital Readmissions Reduction Program has lowered readmission rates in hospitals and allowed hospitals to provide medically necessary care in less costly settings, such as PBDs.
- The two-midnight policy has shifted care to the outpatient setting.

- Physician referrals to PBDs have increased for services the physicians do not perform in their offices, such as testing and treatments.
- Medicare enrollment has simply grown at a faster pace as the Baby Boomer population ages.

Low Access to Home and Community-Based Infusion

Apart from the increased transition of independent primary care offices into PBDs, CMS also cites as justification for the change in payment policy an increase in the number of medication administration claims submitted by PBDs in recent years. One example that CMS points to is the 70 percent rise in the number of claims that excepted PBDs have submitted for HCPCS code 96413 for chemotherapy administration via IV infusion from 2011 to 2023. CMS also notes that this is the most frequently billed code in the medication administration family by excepted PBDs.

ASH urges CMS to consider how this increase in infusion codes might be interpreted given the lack of access to infusion services, especially for cancer treatment, in the community. Physician offices are usually ill-equipped to support cancer patient treatments in the office because they lack the equipment, so those physicians direct their patients to hospital clinics for infusion. The recently developed Medicare Part B benefit for home infusion therapy, fully implemented in 2021, is not accessible for all individuals quite yet because of gaps in home infusion provider coverage areas and large patient deductible amounts to pay for the skilled services needed to provide infusion in the home. For these reasons, specialists offer patients the choice to come to a PBD or even have an inpatient hospital stay to receive their required infusion treatments. That does not make the increased volume of medication administration services unnecessary.

Reducing the payment to these hospital-based infusion clinics will not help Medicare beneficiaries get the treatments they need in the most appropriate setting. This policy would lead physicians to order patients infusion treatment in an inpatient setting, sending immuno-compromised patients travelling to large academic medical centers in the city for their care. ASH recommends CMS take a broader look at the intersection of the home and community-based infusion volumes and the claims data related to medication administration. We believe the agency will find that this is not about a shift in the ownership of independent physician offices to hospital-owned practices, but rather a shift from home to clinic that can be addressed by home infusion benefit changes or infusion service improvements in physician offices rather than a decrease to OPPS payments.

CMS Needs Additional Latitude from Congress

CMS explained in the rule that it is drawing on its authority to control unnecessary increases in the volume of outpatient services to propose this change in medication administration reimbursement, however we believe this issue is better addressed by securing specific statutory authority from Congress. Unlike the policy in the proposed rule, legislation can be carefully developed to give CMS the authority to exempt certain services or provider types from site neutral payment policies. ASH is currently working with Congress to develop site neutral legislation that includes exemptions for safety-net providers that cannot sustain reductions in payment for Medicaid and Medicare. Without the nuance with which legislation can empower CMS, the proposed cut to PFS-equivalent payment rates will hit all excepted PBDs without moving the needle on CMS's concerns over health system acquisition of primary care practices.

Under Section 603 of the BBA of 2015, Congress specifically stated that off-campus provider-based locations that existed prior to November 2, 2015 would be grandfathered from site-neutral payment reductions that apply to new off-campus locations. Likewise, Congress and CMS can work with stakeholders to identify providers that need protection from new PFS-equivalent payment rates for outpatient services.

Future Volume Control Methods

In this rule, CMS asked for comments on how or whether to develop a systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity. The agency also requested information on expanding the proposed medication administration volume control method to on-campus clinic visits. As outlined above, ASH urges CMS to work with Congress to determine the best way to move forward with site neutral payment policies rather than broaden the scope of this proposal to new services and produce unintended consequences for beneficiaries.

Elimination of the Inpatient Only List

CMS proposed to phase out the inpatient only (IPO) list over three years, beginning with the removal of 285 mostly musculoskeletal services for CY 2026, in recognition of the migration of more surgical procedure volumes to ambulatory surgical centers and other outpatient settings. ASH does not support this change at this time. We urge CMS to withdraw this proposal and take time to study carefully the safety implications and the out-of-pocket financial impact on Medicare beneficiaries that could arise when moving procedures to outpatient settings.

The IPO list has been a reliable safeguard to ensure that all Medicare patients receive complex procedures in the safest possible setting. While individualized physician assessments are important and should remain part of the equation, we believe it is critical for CMS to maintain its role in annually determining which services are ready to be safely provided in an outpatient setting. ASH agrees that some ambulatory settings have increased their volume of outpatient orthopedic surgeries in recent years, but this should not be taken as indication that all 285 of the musculoskeletal procedures proposed for removal are always safe as outpatient procedures. Removing these services from the IPO list creates a financial incentive for practitioners to order outpatient delivery because inpatient reimbursement will be more difficult to reach due to the two-midnight rule (following the proposed grace period from two-midnight audits) and other payment conditions for hospital reimbursement. ASH is concerned that this will leaves patients vulnerable to unsafe clinical decisions, and without the annual IPO list review, CMS will no longer have a mechanism to protect those patients from inappropriate treatment choices.

In addition to the clinical safety implications, CMS should evaluate how removing the IPO list could impact beneficiary co-pays and deductible amounts, and in turn, payment collection challenges for facilities. Medical debt is a huge problem in the U.S. and disproportionately impacts safety-net hospital patients who are underinsured or uninsured. We request CMS address these potential results of the IPO changes in the final rule so that patients can fully understand the potential effects of these financial burdens and whether they create barriers to needed care or disincentives to perform needed outpatient procedures.

Hospital Price Transparency

For standard charges that are based on percentages or algorithms, CMS proposed to remove the requirement for hospitals to encode the estimated allowed amount and instead require them to disclose the 10th percentile, median, and 90th percentile allowed amounts in machine-readable files (MRFs). ASH understands the importance of offering patients the pricing information they need to make health care decisions, but we are concerned that the burden that the price transparency requirements are placing on hospitals – including the new burdens proposed in this rule – now far outweigh the utility of this information for patients. Individuals are most concerned with how much they will be paying out-of-pocket for health care services when they are in the hospital. The amount the payer pays the hospital does not have a bearing on the patient's choice of hospital provider or willingness to schedule services. To truly empower the

patient, CMS should focus on out-of-pocket estimator tools that are loaded with data from the insurance companies rather than the hospitals, so that patients can have prices that are specific to their own plan and deductible.

Quality Reporting Programs

CMS proposed removing from the hospital outpatient quality reporting (OQR) program and the ambulatory surgical center (ASC) quality reporting program the Hospital/Facility Commitment to Health Equity (HCHE) measure, the Screening for Social Drivers of Health (SDOH) measure, and the Screen Positive Rate for SDOH measure.

We urge CMS to maintain SDOH measures that have become foundational to advancing equitable care for all. These standards provide a common language, create accountability, and support systematic approaches to addressing health disparities and community health solutions. SDOH screenings identify barriers like food insecurity and transportation challenges, for example, issues that affect all populations and directly influence outcomes, utilization, and cost. Medicaid and low-income families often need community-based support with social and economic needs and without these screenings, hospitals will not have the tools they need to help.

Conclusion

The Alliance of Safety-Net Hospitals appreciates the opportunity to comment on the proposed rule and welcomes any questions CMS may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director