September 15, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

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, July 17, 2025.

Dear Administrator Oz:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our more than 80 hospitals, healthcare, and affiliated health system members, we are pleased to present CMS with the following comments on the Calendar Year (CY) 2026 hospital outpatient prospective payment system (OPPS) proposed rule.

Hospitals are the cornerstone of America's healthcare system, delivering vital, around-the-clock care to hundreds of millions each year. They play a pivotal role in emergency response, specialized medical treatment, and chronic disease management, while also serving as major employers and economic drivers in their communities. As demand for healthcare services continues to grow nationwide, hospitals are also contending with significant cost increases driven by inflation, workforce shortages, and rising supply expenses. It is imperative that Medicare payment policies promote the long-term sustainability and accessibility of these essential providers. Compounding these challenges, the substantial Medicaid cuts enacted under HR 1 will further erode hospital finances, a development that threatens both the stability of safety-net institutions and the availability of care for vulnerable patient populations.

In light of these challenges, we are disappointed with the inadequate rate increases set forth by CMS in the CY 2026 hospital OPPS proposed rule. The proposed net payment update of 2.4% is simply inadequate given the unrelenting financial headwinds faced by hospitals and health systems. We are particularly concerned with the inappropriately large productivity cut that is being proposed. We urge the agency to re-examine the magnitude of this adjustment and its impact on Medicare payments. Moreover, the inadequate rate increase, combined with an additional 2.0% reduction due to the proposed expedited 340B remedy timeline, will place

significant strain on hospital operations, which is compounded by payment updates that consistently lag behind inflation.

We are also deeply concerned with certain proposals that CMS has set forth in this rule. Taken together, they would negatively impact beneficiary access to hospital-level care and new technologies, while also greatly increasing hospital regulatory burden. These proposals raise even more urgent concerns when considered in the context of the significant Medicaid cuts recently enacted by Congress, which alone pose an existential threat to many hospitals. Specifically, we oppose CMS' proposals to:

- Collect market-based payment rate information by MS–DRG on the Medicare cost report for cost reporting periods ending on or after Jan. 1, 2026;
- Accelerate the clawback of funds under 42 § 419.32(b)(1)(iv)(B)(12);
- Conduct a drug acquisition cost survey of all hospitals paid under the OPPS;
- Add additional burdens to price transparency requirements, as hospitals are already stretched incredibly thin;
- Reduce payment for all drug administration services furnished in excepted off-campus hospital outpatient departments to the "physician fee schedule (PFS)-equivalent" rate;
- Eliminate the inpatient only list over three years; and
- Remove health equity and COVID-19 quality reporting measures.

Our comments are detailed below.

OPPS PAYMENT UPDATE

AzHHA remains deeply concerned about the persistent inaccuracies and inadequacies in market basket updates. In recent years, CMS's market basket forecasts have consistently underestimated actual growth. Moreover, even realized market basket increases have failed to keep pace with general inflation, despite clear evidence of medical inflation outstripping broader economic trends. **When combined with the productivity adjustment, which is not appropriate for the hospital sector, Medicare's payment updates have become increasingly insufficient. Therefore, we urge CMS to exercise its authority under "special exceptions and adjustments" to eliminate the productivity cut for CY 2026**.

Hospitals and Health Systems Continue to Face High Rates of Inflation

Hospitals and health systems continue to face serious inflationary pressures. Unprecedented levels of inflation have raised labor, drug, supply and other costs. A report from the American Hospital Association (AHA) found that in 2024 alone, hospital expenses grew by 5.1%.[1] A large portion of this growth is attributable to increased labor costs. An analysis by AHA found that hospital employee compensation grew by 45% between 2014 and 2023.[2] AHA has also found that advertised salaries for nurses have risen 26.6% in the last four years.[3] Such labor-related

[1] AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).
[2] AHA. America's Hospitals and Health Systems Continue to Face Escalating Operational Costs and Economic Pressures as They Care for Patients and Communities (April 2024) (https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf).
[3] AHA; The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).

inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[4]

In addition to labor costs, increasing drug and supply costs have also strained hospital finances. A recent report from HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.[5] Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on hospital operations.[6] This has a substantial impact on hospitals and health systems as they care for patients with a wide range of complex medical conditions.

In addition to direct costs of care, hospitals have also faced rising administrative costs. For example, the vast majority of Medicare Advantage (MA) plans require prior authorizations. As such, hospitals and health systems spend substantial amounts of time and resources navigating the prior authorization process. A 2021 study by McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations.[7] Additionally, a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials — more than half of which was wasted on claims that should have been paid out at the time of submission.[8] Notably, many of these denials were ultimately overturned as noted above. In fact, a study by the HHS Office of Inspector General (OIG) found that 75% of care denials were subsequently overturned.[9] Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers substantially more than traditional Medicare in 2023.[10,11] MA plans do not reimburse these costs, which instead must be absorbed by hospitals and health systems as they continue to care for a rising proportion of MA patients.

In addition, other economic headwinds are creating uncertainty. Despite ongoing efforts to build the domestic supply chain, the U.S. health care system relies significantly on international sources for many drugs, devices, and other supplies needed to both care for patients and

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[4] ASPE Office of Health Policy. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).

[5] ASPE. Changes in the List Prices of Prescription Drugs, 2017-2023. (Oct. 2023). (https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs)

[6] American Society of Health-System Pharmacists. Severity and Impact of Current Drug Shortages (June 2023) (https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf).

[7] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf

[8] Premier. (2024). Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

[9] DHHS OIG. (2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

[10] MedPAC (2021). MedPAC Report to Congress. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf#page=401

[11] Ensemble Health Partners. (2023). The Real Cost of Medicare Advantage Plan Success. https://www.ensemblehp.com/blog/the-real-cost-of-medicare-advantage-plan-success/

protect our health care workers. Tariffs, as well as any reaction of the countries on whom such tariffs are imposed, could reduce the availability of these lifesaving items in the U.S. Indeed, a recent survey showed 82% of health care experts expect tariff-related expenses to raise hospital costs by at least 15%.[12]

These escalating costs for clinicians, personnel, drugs, and other essentials have put a strain on the entire health care continuum. It has also forced hospitals and health systems to divert funds that could have been invested in patient care, new technologies and other potential efficiencies, making the inadequate market basket updates provided by CMS more concerning.

Market Basket Forecasts Continue to Underestimate Actual Market Basket Growth

During this period of significant cost growth, the market basket forecasts for hospitals consistently failed to accurately predict actual market basket growth. Specifically, since the COVID-19 public health emergency, IHS Global Inc. (IGI) has under-forecasted actual market basket growth each year.

These missed forecasts have a significant and permanent impact on hospitals and health systems and the patients they care for. Further, as CMS knows, future updates are based on current payment levels; therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate for OPPS and will continue to compound.

In truth, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission (MedPAC) projects that 2025 Medicare margins *will be less than negative 13%*, resulting in more than *20 straight years* of Medicare paying below costs.[13] Even among relatively efficient hospitals, the median Medicare margin will remain about *negative* 2%. An AHA analysis showed that Medicare underpayments reached $100 billion in 2023.[14] **This cannot be sustained. Therefore, we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

Productivity

Under the Affordable Care Act, the outpatient PPS payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[15] For FY 2026, CMS proposes a productivity cut of 0.8 percentage points.

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[12] https://www.beckershospitalreview.com/supply-chain/hospital-finance-supply-leaders-predict-15-increase-in-tariff-related-costs/

[13] MedPAC. (2025). MedPAC March 2025 report to the Congress--Chapter 3: Hospital inpatient and outpatient services

[14] AHA. The Cost of Caring: Challenges Facing America's Hospitals in 2025 (April 2025) (https://www.aha.org/costsofcaring).

[15] CMS. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills, and changes in production. **Thus, this measure effectively assumes the hospital field can mirror productivity gains achieved by private nonfarm businesses. However, we discuss in more detail below, it is well proven by the economic literature that the hospital and health care field cannot do this.** For example, by focusing only on private businesses, this measure excludes non-profit and government businesses, which account for more than 60% of hospitals and health systems. Thus, this measure is not an appropriate or reliable predictor of productivity for the hospital field. **As such, we ask CMS to use its "special exceptions and adjustments" authority to eliminate the productivity cut for FY 2026.**

First, measures of productivity contained in the private nonfarm business TFP are not appropriate measures of productivity for the hospital field. Outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell tangible, physical products, measuring these outputs is relatively straightforward and often standardized. However, hospital quantity and prices do not operate in this way. For example, hospital quantity, such as volume of visits or procedures, is not necessarily an appropriate output measure; it may actually be more reflective of the disease burden of a community. More hospital volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses.

In addition, hospital prices per unit of service often cannot be adjusted in response to changes in demand or quality; unlike those of private nonfarm businesses. This is because much of hospitals and health systems' reimbursement is through fixed payments, such as through the outpatient PPS. Moreover, for commercially-insured patients, hospital rates are determined through negotiations, which often lock in the payment rate for several years. Thus, it makes relatively little sense to apply a TFP output function of quantity and prices that is experienced in the private sector to the hospital sector when the same output function does not apply.

Second, the TFP does not reflect specific challenges that prevent hospitals from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, hospitals operate in a complex environment characterized by unpredictable patient volumes, rising input costs, and varying acuity levels, not to mention natural disasters and pandemics. Hospitals also face heavy regulatory burdens beyond those of other industries. For example, hospitals face unique fixed costs such as requirements to keep emergency departments open 24/7 so that patients can seek care at all times. Private nonfarm businesses rarely have such onerous challenges and requirements.

Furthermore, the hospital field is different from private nonfarm businesses because the services provided by hospitals are highly labor-intensive. As discussed in more detail in the appendix, it has long been theorized in the economic literature that sustained productivity gains in service-intensive industries are difficult to achieve given their heavy reliance on labor, which cannot be scaled or automated. Hospitals are, in this way, more similar to fields like education and social assistance. These industries all experience lower total factor productivity

rates. For example, the rates range from -0.4 for educational services to -0.1 for social assistance, compared to 1.9 to 4.9 for mining, oil and gas, information, and professional services, according to the Bureau of Labor Statistics.

In fact, CMS itself has acknowledged that hospitals are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[16] Thus, using the private nonfarm business sector TFP to adjust the market basket inappropriately exacerbates Medicare's chronic underpayments to hospitals.

Additionally, it is puzzling to see how an indicator based on a 10-year moving average could yield a near doubling of the productivity cut in a single year. Specifically, the FY 2025 cut was 0.5%, but this year CMS proposes a cut of 0.8%. Moving from one year to the next, when calculating a 10-year moving average, one only changes a single one of the 10 years; as such, this methodology should smooth fluctuations to a very large degree. Instead, in moving from FY 2025 to FY 2026, we see the productivity cut increase by 60%.

Finally, we find it particularly troubling that the productivity adjustment is used only when it *decreases* Medicare payments. For example, in FY 2021, the 10-year moving average growth of the productivity factor forecasted by IGI was -0.1%. CMS acknowledged that subtracting a negative growth factor from the hospital market basket would have *increased* it by 0.1 percentage points. However, the agency set the productivity factor at 0, stating that it is required to reduce, not increase, the hospital market basket by changes in economy-wide productivity.[17] Simply put, the agency applies the productivity factor only when it cuts Medicare spending. However, the cumulative, compounding effect of these reductions year over year and the asymmetric treatment of declines in economy-wide productivity led to an increasing gap between payments and the cost of providing services, leaving hospitals increasingly underfunded, as discussed above.

Given all of the above, AzHHA continues to have deep concerns about the proposed productivity cut, particularly given the extreme pressures in which hospitals and health systems continue to operate. Applying the private nonfarm business TFP to the hospital field is not appropriate, and in an economy marked by great uncertainty due to tariffs and demand and supply shocks, it generates significant departures from economic reality.

We urge CMS to carefully consider these issues in assessing any future expansion of the Promoting Interoperability program requirements, including lengthening the reporting period.

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[16] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

[17] 85 Fed. Reg. 58797 (Sep 18, 2020).

PROPOSAL TO COLLECT MARKET-BASED PAYMENT RATE INFORMATION BY MS–DRG ON THE MEDICARE COST REPORT FOR COST REPORTING PERIODS ENDING ON OR AFTER JAN. 1, 2026

CMS proposes to collect market-based payment rate data on the Medicare cost report for cost reporting periods ending on or after Jan. 1, 2026. Hospitals would use the payer-specific negotiated charges from their most recent machine-readable file published prior to the submission of their cost report to report the median payer-specific negotiated charge that they negotiated with their Medicare Advantage (MA) organizations. The agency proposes to then use the submitted information to set inpatient PPS relative weights beginning in FY 2029.

This proposal contains serious policy and legal deficiencies. Because of this, we strongly urge its withdrawal. Specifically, this proposal would impose a significant new regulatory burden with no rational basis and ignores critical issues associated with the use of MA negotiated rates to set Medicare fee-for-service MS-DRG relative weights. CMS' assertion that median MA negotiated rates embody market-based prices is inaccurate and overlooks the fact that most MA markets do not resemble competitive marketplaces.

CMS has not and cannot analyze the impacts of its proposed policy because the underlying data are not currently maintained in the format CMS would require. Blindly using MA data to overhaul the inpatient PPS relative weights is improper, and we are very concerned about the substantial negative impacts for our hospitals and the communities we serve. Given these shortcomings, if finalized, the proposal would be arbitrary and capricious because CMS cannot sufficiently explain the dramatic potential shift in regulatory framework. Finally, the proposal is likely not authorized by the cited statutory authority and is actually precluded by other existing statutory requirements.

PROPOSAL TO ACCELERATE THE TIMELINE OF UNLAWFUL CLAWBACK OF FUNDS

AzHHA strongly opposes CMS's proposal to accelerate the clawback of funds under 42 § 419.32(b)(1)(iv)(B)(12). Our affiliated entity, the American Hospital Association (AHA), has explained many times why *any* clawback is unlawful and therefore never should have been finalized. We need not repeat those lengthy arguments here. Instead, we endorse the AHA's legal analysis and urge the agency to reconsider its position. CMS should rescind subsection 419.32(b)(1)(iv)(B)(12) altogether because the agency lacks the statutory authority for *any* such clawback on *any* timeline.

If CMS persists with this unlawful clawback, it should *not* accelerate the existing timeline. When it codified a 16-year timeline in the Final Remedy Rule, CMS stated that it sought to "comply with the statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities." In suddenly changing course, CMS now asserts that it "insufficiently accounted for" what it calls the "main premise of the Final Remedy rule": the need to return 340B hospitals to the financial position they would have been if CMS never implemented its illegal policy in the first place. According to the proposed rule, a 6-year time frame "better

balances that goal and [its] budget neutrality obligations against hospital burden and reliance interests."

This analysis gets the balancing completely wrong because it does not adequately account for changes on the burden/reliance interest side of the equation. First, the proposed rule states: "Because we are proposing this policy in advance of CY 2026 and before any rate reductions go into effect for OPPS and Medicare Fee for Service payments, any reliance interests hospitals have in a policy that has not been implemented yet for these payment systems would be minimal." This reasoning reflects a fundamental misunderstanding of how hospitals operate in the real world.

The hospitals and health systems AzHHA represents make planning decisions about budgets based on what they expect to occur in future years. They therefore began planning for this clawback as soon as CMS announced it in 2023. As an example, one of our member hospitals replaced advanced imaging systems and radiation therapy technology at a cost of $4.5 million and added robotic surgery capabilities at a cost of $2.5 million. And as part of those medium- and long-term planning decisions, they factored in a 0.5 percent clawback.

It therefore makes no difference that those rate reductions have not yet gone into effect. If the agency finalizes this unexpected increase from 0.5 percent to 2.0 percent just two months before 2026, the budgets hospitals and healthcare systems have produced based on that 0.5 percent figure will be thrown out of whack, upsetting settled expectations with little time to readjust and creating serious cash flow problems. That is the paradigmatic reliance interest, and the agency is wrong to state that those interests are "minimal."

Second, CMS also must better account for the burden that the proposed accelerated timeline will inflict on hospitals and healthcare systems. An annual increase from 0.5 percent to 2.0 percent will meaningfully impact providers' margins. As an example, one of our members has estimated that the increase would cause them to reconsider replacing older equipment, which would run the risk of equipment failure impacting the hospital's ability to provide radiation therapy in its cancer center and reducing the ability to provide some surgical services.

Relatedly, the agency's balancing fails to account for adverse financial trends since 2023. As a general matter, costs for Arizona's hospitals and healthcare systems have increased and are continuing to trend in the wrong direction. As you know, government reimbursements continue to remain inadequate. Shifts in care patterns will present hospitals with older, sicker populations that have more complex, chronic conditions, which are more costly to care for.

In addition, our members continue to see an increase in contract labor needs. The proposed rule nowhere considers the recent passage of the One Big Beautiful Bill Act, which will have direct, adverse impacts on our hospital's finances. One of our members estimates that their overall reimbursement will be decreased by $6 million in 2027 and an additional $6 million per year over the next five years. The expected increase in the uninsured population is expected to increase this provider's bad debt and charity care by an estimated $4 million per year. Accordingly, if the agency is truly trying to balance its purported "budget neutrality

obligations against hospital burden and reliance interests," it cannot ignore the effects of the OBBBA or these other financial trends.

All in all, the proposed rule errs by conducting a new balancing that completely fails to account for the burdens that it will impose on hospitals. Although the proposal does not sufficiently explain *how* CMS conducted its balance, it appears as if the agency simply kept the burdens constant from the Final Remedy Rule and readjusted the value of the perceived need to achieve budget neutrality. The final rule *must* discuss and account for these changes on the reliance interest/burden side of the balance. And when it does, the balancing will tip sharply *against* accelerating the timeline.

Finally, the proposed rule fails to consider a sufficient number of alternatives. It states that the agency considered an even faster clawback period (3 years). But the agency fails to explain why it arbitrarily chose that alternative when others exist. The agency easily could have considered timelines between 6 and 16 years. It could have—and should have—considered periods *longer* than the existing 16-year timeframe to better account for post-OBBBA realities. The agency must consider these reasonable alternatives and explain why, in its view, 6 years achieves the needed balance better than these other timeframes.

Ultimately, AzHHA urges CMS to abandon this unlawful, unwise proposal. Because *any* clawback is illegal, CMS should rescind subsection 419.32(b)(1)(iv)(B)(*12*) altogether. If CMS continues to disagree with that legal analysis, it should maintain or extend the existing clawback timeline.

PROPOSAL TO CONDUCT A DRUG ACQUISITION COST SURVEY OF ALL HOSPITALS PAID UNDER THE OPPS

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

Cost acquisition surveys are, in a word, costly. The proposed rule estimates that each hospital will require 73.5 hours to complete the survey at an approximate cost of $4,000. In its 2006 report to Congress about the lessons learned when conducting hospital acquisition cost surveys, the Government Accountability Office stated that the surveys "created a considerable burden for hospitals." Based on our experience with surveys of this kind, this is absolutely true. And based on that same experience, we can tell you that **the proposed rule's estimate grossly underestimates both the cost and time required to complete any survey.**

Ultimately, however, the main reason for abandoning this proposed cost acquisition survey is that its eventual goal should never be pursued. CMS appears to be conducting this survey in service of reducing Medicare reimbursements in CY 2027 and beyond. But Medicare payments *already* lag far behind the costs hospitals incur for providing care to Medicare beneficiaries. Medicare reimbursement continues to lag—covering just 83 cents for every dollar spent by hospitals in 2023, resulting in over $100 billion in underpayments. From 2022

to 2024, general inflation rose by 14.1%, while Medicare net inpatient payment rates increased by only 5.1%—amounting to an effective payment *cut* over the past three years. And in December 2024, the Medicare Payment Advisory Commission noted in a preliminary presentation to Commissioners that hospital Medicare margins had sunk to an all-time low of negative 12.6% and were projected to remain at that level in 2025.

An additional Medicare cut resulting from this proposed survey would be unsustainable. One of our members estimates that the proposed cuts will reduce their operating margin to a negative margin of 1% to 2% within 12 months. Continued operating expense cuts will reduce the availability of services in the provider's community. **Thus, if the goal of this survey is to cut Medicare payments, the survey should not be conducted at all.**

The agency also must keep in mind that any survey results are of limited value, and the specific questions that CMS asks only highlight those limitations. *First*, CMS asks whether it "should make responding to the survey a mandatory requirement of all hospitals paid under OPPS," but CMS identifies no statutory authority for such a mandatory requirement. Section 1833(t)(14)(D)(iii), the only statute cited in that discussion, certainly does not provide the agency with the authority to *mandate* hospital responses. All it does is set forth the requirements for a survey. If Congress wanted to require hospital participation in a drug acquisition cost survey or allow the Department of Health and Human Services Secretary to take enforcement action for a non-response, it would have done so, as it has in other contexts. **Absent such statutory authority, and absent any way to enforce a manufactured response-requirement, the agency must explicitly acknowledge in the final rule that responding to any cost acquisition survey is purely *voluntary***.

Second, perhaps recognizing that it has no legal authority to require a survey response, the agency "welcome[s] comment on how we might propose to interpret non-responses to the survey." The proposed rule includes four options that the agency could use to interpret a hospital's non-response to its survey. But *none of these options* would satisfy the statutory requirement that a survey "…have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug." **Put simply, the agency cannot contrive responses where there are none and then claim that there is a large enough sample size. What's more, the agency's made-up interpretations of non-responses would yield inaccurate data that is in no way "statistically significant." If the agency is truly concerned about the lack of responses from hospitals, it should not issue a survey in the first place.**

PROPOSAL TO REVISE CERTAIN PRICE TRANSPARENCY REQUIREMENTS

AzHHA, its hospitals, and its health systems are dedicated to improving price transparency and look forward to working together with the Administration on this important goal. To that end, we provide the following comments on the proposed rule as well as general comments on price transparency policy.

New Allowed Amount Data Elements

CMS proposes requiring several new machine-readable file data elements, beginning January 1, 2026, in instances when payer-specific negotiated charges are based on a percentage or algorithm. The new data elements include the median allowed amount, the 10th percentile allowed amount, the 90th percentile allowed amount, and a count of all allowed amounts.

At a time when hospital resources are stretched thin, we are concerned about the additional burden the new requirements would place on hospital staff, especially given the short timeline for implementation. Given the added complexity of the new data elements, many hospitals that have previously been able to update their files independently anticipate needing to hire vendors going forward should CMS finalize this proposal. Hospitals expect additional vendor fees of $20,000-$30,000 just to meet these new requirements on such a tight timeframe. In addition, because most hospitals update their files on an annual basis at the start of the year, they will already be in the process of pulling together their files when CMS releases the final OPPS CY26 rule, and it will not be possible to implement the new data elements before January 1, 2026. CMS understood the need for sufficient implementation time when finalizing the "estimated allowed amount" data element in the OPPS CY24 final rule, allowing hospitals more than one year to implement the change. **Thus, we strongly recommend that CMS again allow hospitals at least one year to adopt the new data elements.**

In addition, we have several concerns with CMS' proposed methodology. Requiring hospitals to report the count of all allowed amounts risks violating HIPAA de-identification standards and longstanding federal data suppression policies, as small claim counts—particularly in rural settings or low-volume services—could allow identification of protected information. CMS should return to its prior guidance excluding values derived from 11 or fewer data points, or at a minimum allow hospitals to encode "<12" instead of reporting exact counts. Also, the proposed 12-month lookback period is too short, given hospitals' three-month data pull timelines and claims adjudication lags, which would effectively reduce usable data to only 6–8 months. **To ensure meaningful analyses, CMS should adopt a minimum 18-month lookback period.** Finally, CMS' proposal to use non-standard calculations for medians and percentiles, rather than established statistical methodology, would impose unnecessary custom programming burdens; **hospitals should be permitted to use the standard methodology.**

New Attestation Language

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

In addition, CMS proposes to require CEOs or other senior executives to sign the attestation. This would be unnecessarily burdensome. We ask that the agency not add to the burdens of hospital leaders; instead, CMS should trust the good faith of others within the hospital who are

far closer to the information and can verify its accuracy far more easily than someone higher on the organizational chart with broader responsibility. **Therefore, we encourage the agency not to finalize this proposal.**

General Comments on Price Transparency Policy Reform

The guiding principle of price transparency policies should be providing patients with clear and accurate information to help them plan for care. An important secondary goal should be ensuring employers have the information they need as major purchasers of health care through employer-sponsored coverage. We are concerned that the proposed rule's emphasis on the machine-readable files, rather than the consumer-friendly shoppable service information, diverts attention away from the price transparency efforts that are most meaningful to patients. Surveys and focus groups have shown that consumers find shoppable service files to be confusing and difficult to navigate; instead, they find price estimator tools to provide the information they need more effectively. **We encourage CMS to focus future efforts on the information that will best help patients understand and compare their expected costs prior to care.**

CMS has expressed concern over the reliability of patient estimates that may vary significantly from a patient's final bill and has to-date focused more heavily on the machine-readable file data. However, the machine-readable file data is no more "real" than the information provided by a price estimator tool, and, in fact, it can be less accurate and even misleading in comparison. **Therefore, CMS should not discount the value of price estimates but instead consider taking steps to ensure that pre-service estimates are as accurate as possible.**

Finally, price transparency efforts would benefit from a comprehensive review of the numerous and sometimes conflicting requirements at both the state and federal levels. The current landscape of pricing information is challenging for patients and employers to navigate and use effectively, and it adds excessive costs, confusion and workforce burden to the health care system. **Thus, we urge CMS to focus future efforts to reform price transparency on streamlining policies to reduce the risk of conflicting information while improving accuracy, as well as alleviating costly administrative burden for both providers and insurers.**

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

AzHHA opposes CMS' proposal to reduce the payment for drug administration services furnished in excepted off-campus HOPDs to the "PFS-equivalent" rate of 40% of the OPPS rate. We also oppose the option the agency raises of possibly expanding such site-neutral cuts to other services furnished in HOPDs. **We urge the agency to withdraw these proposals from consideration.**

We believe CMS lacks statutory authority to reduce payments to excepted HOPDs to the level of nonexcepted HOPDs, particularly in a non-budget-neutral manner. The rule states that

"section 1833(t)(2)(F) of the [Social Security] Act provides authority to implement this policy," and that the D.C. Circuit's decision in *American Hospital Association v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), supports its interpretation. But legal developments since that decision cast significant doubt on its continued viability and, more importantly, undermine the agency's reliance on Section 1833(t)(2)(F). Specifically, the proposed rule fails to grapple with three critical legal deficiencies in relying on *American Hospital Association v. Azar*. These are: (1) with the Supreme Court's overturning of the *Chevron* framework, the agency's interpretation of Section 1833(t)(2)(F) is not entitled to deference and does not provide the Department of Health and Human Services (HHS) with statutory authority to implement this policy; (2) more recent Supreme Court decisions like *Biden v. Nebraska* and *West Virginia v. EPA* have strongly emphasized that agencies cannot fundamentally rewrite statutes, but HHS is doing precisely that in using Section 1833(t)(2)(F) to completely evade the OPPS system; and (3) the proposed rule does not address Section 603 of the Bipartisan Budget Act of 2015, which does not cover HOPDs established before November 2015.

In addition, CMS fails to consider other explanations for the increase in drug administration. Indeed, we disagree that higher payments for these services are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." This assertion ignores many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from both Medicare and private payers, as well as excessive administrative burdens. Rural hospitals and health systems have witnessed a growing trend of physician practices being acquired by private equity firms and other corporate entities. As independent practices consolidate under these ownership structures, hospitals often become the only site of care willing to treat medically complex, lower-margin patients, resulting in a higher concentration of drug administrations within HOPDs. This dynamic, rather than reimbursement differentials, helps explain observed increases in service volume.

Next, CMS' proposal equates care provided in hospital clinics with less complex care provided at independent physician offices and other free-standing sites. However, such care is not equivalent, and current OPPS payment rates take into account these significant differences. As an example, unlike independent physician offices, hospitals are required to take many additional measures to make certain that medications are prepared and administered safely while also providing important care coordination services for their patients. Specifically, hospitals must take steps to ensure that a licensed pharmacist supervises drug preparation, rooms are cleaned with positive air pressure to prevent microbial contamination and employees are protected from exposure to hazardous drugs. In addition, hospitals must remain in compliance with important safety standards such as those required by the Food and Drug Administration, U.S. Pharmacopeia, and The Joint Commission.

Finally, the proposal does not account for the fact that HOPDs serve a sicker, more clinically complex and more economically vulnerable Medicare population. Many of our member hospitals' outpatient departments disproportionately serve patients who are older, poorer, and medically fragile, including individuals with multiple chronic conditions. Many of these patients lack reliable transportation, live in medically underserved areas, and rely on Medicaid or Medicare as their primary coverage. These populations are less likely to be cared for in free-standing physician practices, which often lack the resources, staff, and infrastructure to safely deliver high-acuity services, provide comprehensive care coordination, or absorb the financial risks of treating large numbers of underinsured or uninsured patients. In contrast, HOPDs are required to maintain the clinical, safety, and compliance standards necessary to support these vulnerable groups, making them the only realistic site of care for many rural and low-income patients.

PROPOSAL TO ELIMINATE THE IPO LIST OVER THREE YEARS

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

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

QUALITY REPORTING PROPOSALS

AzHHA would also like to comment on proposed changes to a number of quality metrics.

Removal of Health Equity and COVID-19 Measures

CMS proposes the removal of measures including COVID-19 Vaccination Coverage Among Healthcare Personnel, Hospital Commitment to Health Equity, and Screening for and Screen Positive Rate for Social Determinants of Health. The proposed elimination of these equity-focused measures is concerning, particularly in light of the meaningful progress made in Arizona to address health disparities. These measures have played a critical role in identifying gaps in care and catalyzing improvement efforts. We encourage CMS to consider alternative strategies to sustain momentum in advancing health equity.

Modification of Excess Radiation Dose Electronic Clinical Quality Measure (eCQM)

The decision to maintain the Excessive Radiation eCQM as a voluntary measure for an additional two years is a welcome proposal. Hospitals accredited by The Joint Commission may already be reporting this measure, but its implementation poses notable challenges—

particularly for smaller hospitals with limited health IT infrastructure. The measure requires specialized software capable of extracting and translating data from radiology EHR systems, which can be a significant barrier for facilities operating with suboptimal or fragmented electronic records.

Proposed Extraordinary Circumstances Exception (ECE) Policy Updates

We appreciate CMS's proposal to update the Extraordinary Circumstances Extensions (ECE) process for quality reporting programs. The ability to grant automatic extensions in response to systemic issues or region-wide extraordinary circumstances—without requiring individual facility requests—is a thoughtful and pragmatic improvement. This change will help ensure that hospitals, REHs, and ASCs are not unfairly penalized due to events beyond their control, such as natural disasters or widespread technical failures. Additionally, while we recognize the intent behind shortening the request window from 90 to 30 days, we encourage CMS to monitor the impact of this change to ensure facilities have adequate time to assess and respond to extraordinary events. We appreciate the proposals that reflect CMS's commitment to fairness, flexibility, and responsiveness in its quality reporting programs, and we strongly support their adoption.

Thank you for the opportunity to comment on this rulemaking. Please feel free to contact me with any questions.

Sincerely,

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