American Hospital Association™
Advancing Health in America

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August 28, 2026

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

RE: CMS–1850–P, Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; and Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA), (Vol. 91, No. 128), July 7, 2026.

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') hospital outpatient prospective payment system (PPS) and ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2027.

America's hospitals and health systems, including their outpatient departments, are the backbone of the U.S. healthcare system, providing 24/7 care to patients and communities. Hospital care today is more advanced, more effective and more resource-intensive than ever, reflecting major gains in medical innovation and the highly skilled workforce, technology and infrastructure required to deliver it. Patients are living longer, recovering faster and receiving treatments that would have been unimaginable just a generation ago. As communities across the country face ever-increasing demand for healthcare services, it is essential that Medicare payment policies support the sustainability and availability of these providers and services.

Thus, we are concerned the proposed net payment update of 2.4% is not adequate given the unrelenting financial headwinds hospitals and health systems face. We are particularly concerned with the large proposed productivity cut of 0.8 percentage points, and urge CMS to work with Congress to reduce the magnitude of it for CY 2027 or eliminate the adjustment altogether. Moreover, we are concerned about other proposals that would negatively impact beneficiary access to hospital-level care and new technologies, while also greatly increasing regulatory burden. Specifically, we:

- Oppose CMS' proposal to reduce payment for imaging without contrast services furnished by off-campus excepted provider-based departments (PBDs) and urge the agency to withdraw it.
- Recommend that CMS return to its standard process from 2025 for removing procedures from the inpatient-only (IPO) list.
- Recommend that CMS withdraw its proposed expansion of prior authorization to apply to additional botulinum toxin injection codes, which would affect services that are predominately medical, not cosmetic.
- Urge CMS to abandon the proposed expansion of the ASC covered procedures list (CPL) due to safety concerns arising from the inappropriately weakened standard and general exclusion criteria for the ASC CPL.
- Urge CMS to help mitigate the increased burden that the statutory requirement for hospitals to obtain separate National Provider Identifiers (NPIs) for each of their off-campus PBDs would place on hospitals, physicians, payers and Medicare beneficiaries.

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Roslyne Schulman, AHA director for outpatient payment policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President

American Hospital Association
Detailed Comments on the Outpatient Prospective Payment System Proposed Rule for CY 2027

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OUTPATIENT PPS PAYMENT UPDATE

The AHA remains concerned that CMS' proposed annual market basket updates are not keeping pace with real-world cost growth. In recent years, the market basket forecasts have consistently come in below broader inflation, let alone medical inflation, which has exceeded growth in the overall economy. Layered on top of that, the productivity adjustment, proposed to be 0.8 percentage points for CY 2027, further erodes the update, leaving Medicare payments increasingly out of sync with the cost of care. **We urge CMS to revisit both its market basket forecasts and the magnitude of the productivity adjustment, and to consider the combined effect on provider reimbursements. As such, we further ask CMS to work with Congress to reduce the magnitude of productivity adjustment or eliminate the adjustment all together**.

Rising Costs of Care Continue to Strain Healthcare Providers

A net payment update of 2.4% is not sufficient given the serious inflationary pressures hospitals and health systems continue to face. A recent AHA report found that total hospital expenses increased by 7.5% in 2025 alone.[1] Much of this increase reflects labor costs, which CMS notes account for more than half of the market basket. Indeed, an AHA analysis found that workforce costs rose by 5.6% in 2025.[2] Further, advertised salaries for registered nurses have averaged 5.5% growth over the last two years — more than double the rate of inflation.[3] Finally, the AHA has expressed concern that recent actions, such as changes to federal student loan limits that exclude nurses and other clinicians from enhanced borrowing limits, will exacerbate workforce shortages, which contribute to higher costs for labor.

Cost pressures, however, extend well beyond labor. Like other providers, hospitals are increasingly caring for sicker and more complex patients, requiring additional and more costly drugs and supplies. An AHA analysis showed that in 2025, supply costs rose 9.9%, while drug costs rose a staggering 13.6%.[4] The analysis also found that from 2019 to 2024, about 19% of hospital cost growth was driven by caring for sicker, more complex patients, as hospitals devoted more staff time, monitoring and specialized treatment to each case. Another 45% of hospital cost growth can be attributed to higher input costs per patient, such as rising wages and benefits for clinical and other staff, and higher prices for drugs, supplies and equipment. These cost challenges strain hospitals and health systems, which must be prepared to provide treatment for a wide range of conditions and comorbidities.

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[1] AHA. (March 2026) "The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026." https://www.aha.org/costsofcaring
[2] Id.
[3] Id.
[4] Id.

Providers also are absorbing escalating administrative costs that are not reflected in payment updates. 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. In 2025, hospitals spent nearly $18 billion on overturning claims denials alone.[5] All told, using data from the most recent annual survey, the AHA estimates that hospitals spent a staggering $43 billion in 2025 trying to collect payments insurers owed for care already delivered. In addition, in 2024, the average hospital employed about 64 administrative and billing staff dedicated to these functions — roughly 6.5% of total hospital employment — according to AHA analysis of annual survey data. Notably, many of these denials were ultimately overturned. In fact, a study by the Health and Human Services (HHS) Office of the Inspector General (OIG) found that 75% of care denials were subsequently overturned.[6] Making matters worse, MA plans paid hospitals less than 90% of Medicare rates despite costing taxpayers substantially more than traditional Medicare in 2023.[7,8] Since plans do not reimburse these administrative expenses, providers must absorb them while caring for a growing share of MA patients.

Viewed collectively, these cost increases for staffing, drugs and other essential supplies and services are placing significant strain across the healthcare continuum. They also are forcing providers to redirect resources that otherwise could be used to support patient care, adopt new technologies and make other efficiency-enhancing investments. That reality makes CMS' insufficient market basket update even more troubling. As discussed further below, these same pressures also amplify the negative impact of the productivity adjustment on providers' ability to fund the very investments that can drive operational efficiencies.

Concerns with Calculation of the Hospital Market Basket

During this period of significant cost growth, the market basket forecasts for hospitals have consistently failed to accurately predict actual market basket growth. We have detailed these under-forecasts of the market basket and potential drivers of that under-forecast in our past comments. For example, the time-lagged nature of the market basket's construction has resulted in large under-forecasts for several years. Additionally, its construction also does not fully capture the labor dynamics occurring in

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[5] Premier. (2025) "Claims Adjudication Costs Providers $25.7 Billion - $18 Billion is Potentially Unnecessary Expense." https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense

[6] HHS 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

[7] 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

[8] 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/

the healthcare field. While forecasts will never be perfect, in the past, they have been more balanced. However, with rapid changes in the industry, these shortcomings are becoming more pronounced. **The AHA continues to stand ready to work with CMS to examine the market basket compensation indices and proxies to improve the accuracy of these measures.**

Indeed, these trends have continued and exacerbated Medicare's underpayments to the hospital field. The Medicare Payment Advisory Commission (MedPAC) projects that 2026 Medicare margins *will be negative 10%*, resulting in more than *20 continuous years* of Medicare paying below costs.[9] The AHA's own analysis showed that Medicare underpayments reached $100 billion in 2024.[10] **This is unsustainable. 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 more accurately reflect the cost of providing hospital care.**

Compounding Effect of Inadequate Payment Increases

What makes this year's shortfall particularly consequential is that inadequate Medicare payment increases no longer affect only Medicare revenue. As the Medicaid and CHIP Payment Access Commission and others have documented, Medicaid payment rates are increasingly benchmarked to Medicare.[11,12,13,14] Many state Medicaid agencies explicitly tie their fee-for-service rates, managed care payment floors and supplemental payment structures to Medicare payment. When Medicare updates fall short of costs, the ripple effect is felt across Medicaid as well.

Last year's reconciliation bill, and the proposed regulations to implement its provisions, took this a step further by directly limiting certain Medicaid supplemental payments to what Medicare would have paid for the same services. For hospitals that have historically relied on supplemental payments to help offset inadequate base rates, this represents a fundamental change in the fiscal landscape. A below-inflation Medicare

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[9] MedPAC. (2026) "MedPAC Report to Congress." https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf
[10] AHA. (March 2026) The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026 (https://www.aha.org/costsofcaring).
[11] MACPAC. (2018) "State Medicaid Payment Policies for Inpatient Hospital Service." https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/
[12] MACPAC. (2016) "State Medicaid Payment Policies for Outpatient Hospital Services." https://www.macpac.gov/publication/state-medicaid-payment-policies-for-outpatient-hospital-services/.
[13] MACPAC. (2025) "Compendium: State Medicaid Payment Policies for Medicare Cost Sharing." https://www.macpac.gov/publication/compendium-state-medicaid-payment-policies-for-medicare-cost-sharing/
[14] Health Affairs. (2025) "Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees." https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01530

update is no longer simply a Medicare problem; it now functions as a ceiling that constrains Medicaid payment adequacy as well.

As Medicaid payments become increasingly tied to Medicare rates by statute and regulation, a full accounting of the federal fiscal impact of this rule and of its effect on hospital financial viability requires that CMS analyze both programs together. This would provide a more complete and accurate picture of what proposed Medicare payment policies mean for the healthcare system as a whole.

The Productivity Adjustment Exacerbates Insufficient Market Basket Updates

Under the Affordable Care Act (ACA), the outpatient PPS payment update is reduced each year by a productivity factor equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP). The private nonfarm business TFP is intended to reflect gains from new technologies, economies of scale, business acumen, managerial skill and changes in production. As such, it effectively assumes that the hospital field can achieve productivity gains comparable to those realized by private nonfarm businesses. However, as discussed in more detail below and in a report shared last year, the healthcare field cannot mirror these gains. As a result, it is not an appropriate or reliable proxy for healthcare productivity. **Therefore, we ask CMS to work with Congress to reduce the magnitude of the productivity adjustment or eliminate it altogether.**

A core problem is that the productivity construct embedded in the private nonfarm business TFP is a poor fit for measuring healthcare productivity. TFP outputs are measured based on the total quantity and prices of goods and services produced in private nonfarm businesses. In industries that sell tangible products, outputs can often be measured in relatively straightforward and standardized ways. Healthcare outputs, however, do not operate in the same manner. For example, healthcare “quantity,” such as volume of visits or procedures, is not necessarily an appropriate proxy for output; it may instead reflect the underlying disease burden in a community. More provider volume — i.e., more quantity — does not equate to higher productivity in the way it can for other private nonfarm businesses.

Further, providers often cannot adjust prices per unit of service in response to changes in demand or quality in the way private nonfarm businesses can. Much of hospitals’ and health systems’ reimbursement is paid through fixed payment systems, such as the outpatient PPS, which limits providers’ ability to alter prices. Similar constraints apply in the commercial market: Providers do not unilaterally set their rates, and prices for commercially insured patients are established through negotiations that frequently lock in rates for multiple years. Accordingly, applying a TFP output framework based on quantity and prices — as experienced in other sectors — to healthcare providers is problematic because that output function does not translate to the healthcare field.

In addition, the hospital field also differs from many private nonfarm industries because healthcare services are inherently labor-intensive. As discussed further in the report referenced above, economic literature has long recognized that sustained productivity gains are difficult to achieve in labor-intensive service industries because labor cannot be scaled or automated in the same way as in other sectors. In this respect, healthcare providers are more comparable to fields such as education and social assistance, which tend to experience lower total factor productivity rates. For example, Bureau of Labor Statistics data show rates ranging from -0.4 for educational services to -0.1 for social assistance, compared with 1.9 to 4.9 for industries such as mining, oil and gas, information, and professional services.

Finally, we continue to find it especially troubling that the productivity adjustment appears to be applied only when it *reduces* Medicare payments. For example, in 2021, the 10-year moving average growth of the productivity factor forecast was -0.1%. CMS acknowledged that subtracting a negative growth factor from the market basket would have *increased* it by 0.1 percentage point. However, the agency set the productivity factor at 0, stating that it is required to reduce — not increase — the market basket by changes in economy-wide productivity.[15] Put simply, the agency uses the productivity factor only when it lowers Medicare spending.

The cumulative, compounding effect of these annual reductions — coupled with the asymmetric treatment of periods of declining economy-wide productivity — has widened the gap between payments and the cost of providing services, leaving providers increasingly underfunded, as discussed above. Therefore, the AHA continues to have serious concerns about the proposed productivity cut, particularly given the extraordinary pressures under which healthcare providers continue to operate.

SITE-NEUTRAL REDUCTION IN PAYMENT FOR IMAGING WITHOUT CONTRAST SERVICES IN EXCEPTED OFF-CAMPUS PBDS

Section 603 of the Bipartisan Budget Act of 2015 (BiBA) requires that, except for dedicated emergency department (ED) services, services furnished in off-campus PBDs that began billing under the outpatient PPS on or after Nov. 2, 2015 (referred to as “non-excepted” services), are not paid under the outpatient PPS. Instead, these non-excepted services are required to be paid under another applicable Part B payment system, which CMS defined as 40% of the outpatient PPS rate. Services furnished in off-campus PBDs that were billed under the outpatient PPS before Nov. 2, 2015, were not intended to be subject to the site-neutral payment reductions and are referred to by CMS as “excepted.”

[15] Federal Register. 85 Fed. Reg. 58797 (Sept. 18, 2020)

In the 2019 outpatient PPS final rule, CMS described "unnecessary" increases in the volume of hospital outpatient clinic visits in excepted hospital off-campus PBDs and, citing a provision in section 1833(t)(2)(F) of the Social Security Act, finalized a policy to pay for these excepted (or grandfathered) clinic visits at the 40% of the outpatient PPS rate.[16] In the 2026 outpatient PPS final rule, CMS expanded this policy to include drug administration services furnished in grandfathered off-campus PBDs. Both site-neutral policies were implemented in a non-budget-neutral manner, and both exempted rural sole community hospitals (SCHs).

In the 2027 outpatient PPS proposed rule, CMS put forth another expansion of its site-neutral payment policy. The agency claims that financial incentives drive service volume increases for imaging without contrast services, leading to "unnecessary" Medicare spending and higher out-of-pocket costs for beneficiaries. Therefore, starting in 2027, CMS would pay 40% of the outpatient PPS rate for all imaging without contrast services ambulatory payment classifications (APCs), including composite APCs, furnished in excepted off-campus PBDs. The agency would again exempt rural SCHs from the cuts and again implement them in a non-budget-neutral manner.

The AHA opposes CMS' proposal to reduce payment for imaging without contrast services furnished by off-campus excepted PBDs and urges the agency to withdraw it. In short, the agency:

- Fails to consider that hospital outpatient departments (HOPDs) are more likely to serve Medicare patients who are sicker, more clinically complex, and more likely to be disabled or living in poorer, rural communities than patients treated in independent physician offices (IPOs).
- Fails to consider other reasonable explanations for the increase in the volume of imaging without contrast services in excepted off-campus PBDs.
- Inappropriately compares OPPS and physician fee schedule (PFS) payment rates.
- Fails to account for the fact that hospitals and health systems invest in their communities to provide essential benefits and advance healthcare for all Americans, and these investments are unfunded.
- Ignores the harmful impact that its proposal would have on rural access to care.
- Lacks statutory authority to reduce payments to off-campus excepted PBDs, particularly in a non-budget-neutral manner.

CMS' Proposal Fails to Account for the Fact that HOPDs Serve a Sicker, More Clinically Complex and More Economically Vulnerable Medicare Population

[16] "(2) SYSTEM REQUIREMENTS.— Under the payment system—… (F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services."

The AHA is concerned that the proposed site-neutral payment reduction would force hospitals to scale back some of the critical services they are able to provide to their patients. This is of great concern because HOPDs care for a larger share of sicker, higher-need individuals, including those from rural and lower-income communities, making them a critical access point for essential care.

In fact, a recent study comparing beneficiaries treated in IPOs to those treated in HOPDs found that beneficiaries receiving care in HOPDs are:

- 54% more likely to be under 65 and disabled.
- 60% more likely to reside in a rural county.
- 61% more likely to be dually eligible for Medicare and Medicaid.
- 67% more likely to have a major complication or comorbidity (MCC)
- More likely to have recently used hospital care, including:
    - 73% more likely to have prior emergency department visits.
    - 114% more likely to have prior inpatient hospitalizations.[17]

Moreover, a related study comparing beneficiaries with cancer seen in IPOs to those treated in HOPDs found several more substantial differences. Beneficiaries with cancer receiving care in HOPDs are:

- 131% more likely to be under 65 and disabled.
- 75% more likely to reside in a rural county.
- 125% more likely to be dually eligible for Medicare and Medicaid.
- 63% more likely to have an MCC.
- More likely to have recently used hospital care, including:
    - 63% more likely to have prior ED visits.
    - 113% more likely to have prior inpatient hospitalizations.[18]

An analysis conducted by AHA using 2025 Medicare claims data[19] examines beneficiaries receiving imaging without contrast services — the very services CMS is proposing to cut.

This analysis finds that beneficiaries receiving these services in HOPDs are:

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[17] KNG Health Consulting, LLC. (September 2025) "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024." https://www.aha.org/comparison-care-hospital-outpatient-departments-and-independent-physician-offices

[18] KNG Health Consulting, LLC. (September 2025) "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024." https://www.aha.org/comparison-care-hospital-outpatient-departments-and-independent-physician-offices-among-cancer-patients-updated-findings-2019

[19] Medicare fee-for-service claims. Centers for Medicare & Medicaid Services. Chronic Conditions Data Warehouse. https://www.ccwdata.org/

- 51% more likely than beneficiaries receiving the same services in IPOs to be dually eligible for Medicare and Medicaid;
- 64% more likely to be disabled; and
- 58% more likely to have end-stage renal disease (ESRD).

While our analysis examines a more targeted population and an overlapping but not identical set of factors, these service-specific findings are directionally consistent with the broader KNG Health Consulting analyses discussed above, reinforcing that the patient population differences CMS should consider are not only limited to hospital outpatient care generally but are also present specifically among beneficiaries receiving the services targeted by this proposal.

This same analysis also finds that beneficiaries receiving imaging without contrast services in HOPDs carry a meaningfully greater burden of conditions considered to be complications and comorbidities (CCs) and MCCs than beneficiaries receiving these services in IPOs. While HOPD beneficiaries are already somewhat more likely than IPO beneficiaries to have at least one CC or MCC, this gap widens substantially as clinical complexity increases.

HOPD beneficiaries are:

- 50% more likely than IPO beneficiaries to have five or more CCs; and
- 92% more likely to have five or more MCCs.

On average, HOPD beneficiaries also have approximately 40% more CCs and 66% more MCCs than beneficiaries seen in IPOs. These findings, which isolate beneficiaries receiving the specific services CMS proposes to cut, provide further evidence that the population CMS proposes to subject to site-neutral payment reductions is not only more likely to be dually eligible, disabled, or have ESRD, but is also meaningfully sicker and more clinically complex than the population served in IPOs.

We continue to be opposed to CMS' site-neutral reductions for drug administration services as well. Our findings for beneficiaries receiving these services in HOPDs versus IPOs are directionally consistent with those observed for both the overall outpatient population and beneficiaries receiving imaging without contrast services.

Consider an example that describes two Medicare patients who need the same MRI procedure but require very different levels of support, time and resources. The first patient, a 76-year-old woman with swallowing and airway concerns, receives an MRI at a freestanding imaging center. She completes the scan without incident, requiring minimal staff time. The second patient, an 82-year-old man with moderate dementia living in a care center, needs an MRI after vomiting and showing signs of a possible medical issue. Because of his cognitive impairment and care needs, he must be scanned in a hospital setting rather than a freestanding imaging center. The HOPD

scan requires additional staff support, metal screening, assistance changing, reassurance during the scan and use of an open MRI because he has difficulty staying still. As a result, the scan takes about four times longer than a comparable MRI at a freestanding center and involves multiple technicians. Although the procedure is coded the same, the hospital-based scan takes far more time and staff support and is much more costly to provide.

CMS Fails to Consider Other Explanations for the Increase in Volume of Imaging Without Contrast Services in HOPDs

CMS claims that higher payments for imaging without contrast services under the outpatient PPS are incentivizing hospital acquisition of IPOs and, therefore, leading to an "unnecessary increase in the volume of services." The AHA disagrees with this assertion. Indeed, it is worth noting that while disproportionate attention has been placed on hospitals' acquisition of physician practices, other entities, such as commercial insurers, have collectively invested billions of dollars in physician practice acquisitions. For example, based on an AHA analysis of Levin Associates data, private equity, physician groups and health insurers acquired the vast majority of physician practices from 2019 to 2023.[20] Comparatively, hospitals and health systems accounted for only 6% of acquisitions during this period.

In addition, CMS' assertion ignores the many factors that have led physicians to abandon private practice and seek employment in HOPDs. The fact is, when hospitals acquire independent physician practices, it often occurs because the physicians have reached a tipping point — their practices are failing due to, for example, poor payer mix, increasing regulatory and administrative burden, and declines in reimbursement. Other challenges confronting physicians include rising burnout rates, escalating input costs, including the rapidly rising costs of drugs and other supplies, and a shrinking workforce. However, despite these issues, Medicare physician payments have been declining. Specifically, the Medicare PFS conversion factor declined by over 13% in real dollars from 2001 to 2024.[21] The American Medical Association reports that between 2001 and 2025, Medicare physician pay remained virtually flat even though the cost of running a medical practice increased 59%. Adjusted for inflation in practice costs, Medicare physician pay declined 33% from 2001 to 2025.[22] Compounding this problem is that most other healthcare payers use Medicare reimbursement rates as an anchor for their

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[20] AHA. (2023) "Setting the Record Straight: Private Equity and Health Insurers Acquire More Physicians than Hospitals." https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf

[21] American Medical Association. (2024) "Medicare trustees warn of payment issue's impact on access to care." https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care

[22] Regulations.gov. (2025) "Comment on CMS-2025-0304-0009." https://www.regulations.gov/comment/CMS-2025-0304-11614

own payments. As such, many physicians can no longer cover the costs of providing care.

This financial strain, coupled with mounting pressure to maintain productivity, has led more physicians to leave private practice. Those who do find hospital-based employment obtain greater financial stability, reduced administrative burden and better access to institutional support. This trend is especially evident in rural and otherwise underserved areas, where financial margins are often thinner, patient volumes are lower and physicians face heightened challenges in sustaining independent practices. Indeed, hospitals have become central to preserving access to care by absorbing physicians into their systems, offering more sustainable compensation models and ensuring that communities continue to have access to essential medical services despite the challenges facing independent practices.

Direct Comparison Between OPPS and PFS Payment Rates Is Inappropriate

As part of its rationale for proposing cuts to imaging services without contrast services, CMS cites payment differences between the outpatient PPS and physician office settings. With all due respect, direct comparisons between these two payment rates is inappropriate. The outpatient PPS and PFS are fundamentally different payment systems that are built using different methodologies and cost structures. For example, under the outpatient PPS, APC payment rates are based on hospital cost data and include numerous packaged items, services, supplies and supportive resources associated with furnishing outpatient care. Specifically, CMS has long packaged many integral, ancillary, dependent and supportive services into a single outpatient PPS payment. By contrast, PFS rates are based on relative value units (RVUs) for physician work, practice expense and malpractice expense. These RVUs are determined in part using survey data over which CMS has expressed concerns regarding accuracy, representativeness and reliability. The calculation of PFS rates is not designed to reflect the broader operational, regulatory, staffing, standby-capacity and infrastructure requirements of HOPDs. As a result, comparing payment rates for an individual imaging procedure across the two payment systems does not provide a complete picture of relative resource consumption or total episode costs. Such comparisons also fail to account for important differences in patient complexity, emergency preparedness obligations, compliance requirements, care coordination responsibilities and the availability of hospital-based services that support the furnishing of outpatient care.

Moreover, CMS has not presented sufficient encounter-level analyses demonstrating that payment differences for individual imaging procedures translate into excess program spending when evaluated across the full patient encounter. Focusing on a single service line item rather than the total resources required to furnish care is an oversimplification.

Hospitals and Health Systems Invest in Their Communities to Provide Essential Benefits and Advance Healthcare

Hospitals and health systems make significant investments in resources to provide essential benefits and advanced levels of healthcare to their communities. These community benefits have value that accrue to not only Medicare beneficiaries but all Americans. However, none of these roles are specifically funded. Indeed, hospitals must cover their costs through direct patient care revenue. Below are some of the core clinical benefits they offer:

- Providing free or discounted medical services to low-income, uninsured and underinsured individuals.
- Providing 24/7 essential services, such as maintaining critical infrastructure like EDs, trauma units, burn centers and neonatal care.
- Maintaining and exercising their standby capacity and resources to respond to local disasters and other emergencies.
- Providing health screenings and education for their communities, such as mobile wellness vans, vaccination drives and chronic disease management seminars.

Many hospitals and health systems also support upstream social determinants of health for their communities, such as partnering with local food banks, funding fresh produce pantries and supporting community nutrition education, as well as providing transportation access which helps patients reach critical medical appointments.

Hospitals and health systems also play a central role in advancing imaging technology and improving the quality and efficiency of imaging services. Their clinical infrastructure, specialized workforce and investment capacity support the development and adoption of more sophisticated imaging capabilities across the healthcare system. This includes incorporating emerging tools, such as artificial intelligence, that can help improve workflow, enhance interpretation and support more timely patient care.[23]

The AHA urges CMS to consider the value that such benefits provide to beneficiaries and their communities. Outpatient PPS payment rates must be sufficient to support these higher standards of care that CMS and other regulators require to be met in hospital-based settings.

CMS' Proposal Would Harm Rural Access to Care

Hospitals and health systems play critical roles in preserving access to care for patients in rural communities. They have increasingly stepped up to fill gaps by investing in access points like HOPDs. These care sites provide essential services for rural and low-income communities. Oftentimes, hospitals have been a lifeline for struggling rural physician practices by helping to keep their doors open.

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[23] Wissen Research. (2026) "Artificial Intelligence (AI) In Healthcare Market." https://www.wissenresearch.com/artificial-intelligence-ai-in-healthcare-market/

A further site-neutral payment reduction would jeopardize access to essential care and services for all patients, but especially those in rural and other underserved areas.[24] While the AHA appreciates CMS' proposal to exclude rural SCHs from these cuts, we urge the agency to also consider the rural communities whose hospitals would still face a 60% payment cut for essential imaging without contrast services. It is clear that Medicare beneficiaries in rural communities disproportionately rely on HOPDs to meet their increased healthcare needs. In fact, the more rural the county that a beneficiary lives in, the more likely it is that their visits will take place in an HOPD rather than a physician's office. For example, in counties where 90% or more of the population lives in a rural area, 36% of physician visits are provided through an HOPD. That number drops to 25% of physician visits for the least rural counties.[25]

CMS Lacks the Legal Authority for This Proposal

CMS lacks statutory authority to reduce payments to excepted HOPDs, particularly in a non-budget-neutral manner. Last year, the AHA explained why CMS lacked the legal authority for a similar site-neutral payment reduction. The AHA's arguments and rationale also apply to this current proposal. Rather than repeating those arguments, we incorporate and reiterate them here.

Expanding the "Method for Controlling Unnecessary Increases in the Volume of Covered HOPD Services" to Other Outpatient Department Services

In the proposed rule, CMS also seeks comment on other ways or other services to which it should expand its site-neutral payment reductions. **For all the reasons discussed above, the AHA is strongly opposed to *any* proposals to expand site-neutral payment cuts. To do so would fundamentally rewrite the law by using the described "method" to evade the outpatient PPS system.** Specifically, the current Medicare outpatient PPS, as enacted by Congress, as well as its resulting payments (despite being substantially less than the cost of care), recognize that HOPDs are unique — they treat sicker, more complex patients from medically underserved populations, and they also follow more rigorous licensing, accreditation and regulatory requirements compared to other care settings.[26] Hospitals and health systems, including their HOPDs, need sufficient financial and operational resources to provide high acuity and emergency preparedness and response services that only they can provide. This includes maintaining 24/7 capacity to respond to natural and man-made disasters, public health emergencies and other unexpected traumatic events. It also means being available to care

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[24] AHA. (January 2024) "Analysis: Hospitals and Health Systems Are Critical to Preserving Access to Care for Rural Communities." https://www.aha.org/news/headline/2024-01-25-analysis-hospitals-and-health-systems-preserve-access-care-rural-communities
[25] KNG Health Consulting calculation using 5% Outpatient and Carrier Standard Analytic Files, 2019-2021
[26] AHA. (March 11, 2026) "The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026." https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

for all individuals experiencing an emergency, regardless of their ability to pay. Further site-neutral cuts may result in hospitals closing or reducing these vital services, reducing patient access in communities nationwide, particularly in rural and underserved areas.

YEAR TWO OF ELIMINATING THE IPO LIST

In the outpatient PPS/ASC final rule for CY 2026, CMS established a policy to phase out the IPO list over three years. As such, for CY 2027, CMS proposes to remove an additional 637 services from the following clinical families: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary. These services represent approximately half of the 1,438 services currently remaining on the list. CMS indicates the 801 services that would remain are generally more complex and will require additional consideration, but it still expects these remaining procedures to be evaluated for removal in CY 2028.

The AHA continues to oppose CMS' policy to remove additional procedures from the IPO list. Instead, we once again recommend CMS withdraw this policy and return to the standard process, last used in 2025, for removing procedures from the IPO list.

The IPO list was established to protect beneficiaries. Many of its services are surgical procedures that are high risk, complicated and invasive. Patients may be subject to severe blood loss, multiple days in the hospital, and an arduous rehabilitation and recovery period. These services were determined to require care and coordinated services, as well as the rescue resources and rapid response teams of the inpatient setting of a hospital. We strongly believe that the appropriate setting for these procedures should be determined only with a careful focus on patient safety and peer-reviewed evidence. As such, we are concerned that CMS continues to propose this blanket policy to essentially remove all procedures without an examination of safety or other implications. Indeed, many of the procedures proposed for removal in 2027 are "open" procedures that continue to exhibit the risk characteristics described above. [27] Therefore, they merit additional procedure-specific review prior to removal from the IPO list.

CMS also should consider the fact that more than one-third of all Medicare beneficiaries live with four or more chronic conditions, and more than one-quarter have one or more limitations in activities of daily living that constrain their ability to function independently, which could make these procedures even more complicated and risky if furnished in

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[27] An open procedure (or open surgery) is a medical operation where a surgeon makes a large single cut in the skin and tissue. This gives the doctor a direct view and clear touch of the organs or body parts needing treatment. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/methods-of-surgery

outpatient settings.[28] Thus, we urge CMS not to eliminate these procedures without further, careful scrutiny based on the original general criteria for IPO list removal. These include, for example, analysis of average length of stay, peer-reviewed evidence, patient factors including age, co-morbidities and social support, and other factors relevant to positive patient outcomes.

More specifically, among the 637 procedures proposed for removal in CY 2027, there are numerous services that our physician experts strongly believe would *never* be appropriate to furnish in an outpatient setting and certainly not next year. The following examples illustrate why a procedure-specific evaluation remains necessary before services are removed from the IPO list; note that many of these open surgical procedures continue to require inpatient-level resources, monitoring and clinical oversight despite advances in surgical techniques and perioperative care.

Lung Resection

- Proposed procedures/CPT codes:
    - 32440 – Remove lung pneumonectomy
    - 32442 – Sleeve pneumonectomy
    - 32445 – Removal of lung, extrapleural
- These CPT codes are equivalent to the following ICD-10-PCS codes:
    - 0BTK0ZZ – Resection of right lung, open approach
    - 0BTL0ZZ – Resection of left lung, open approach
    - 0BTM0ZZ – Resection of bilateral lungs, open approach
- Which group to the following MS-DRGs:
    - MS-DRG 163 –Major Chest Procedures with MCC
    - MS-DRG 164 – Major Chest Procedures with Complication or Comorbidity (CC)
    - MS-DRG 165 – Major Chest Procedures without CC/MCC

The AHA recognizes that advances in thoracic surgery, anesthesia, perioperative care and Enhanced Recovery After Surgery protocols have improved outcomes for patients undergoing pulmonary resection procedures. In particular, minimally invasive approaches such as video-assisted thoracoscopic surgery and robotic-assisted surgery have been associated with shorter lengths of stay, reduced postoperative pain and lower complication rates for appropriately selected patients. These advances may

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[28] Kaiser Family Foundation. (Oct. 8, 2025) “Medicare 101.” https://www.kff.org/medicare/health-policy-101-medicare/?entry=table-of-contents-what-is-medicare

support greater flexibility in site-of-service determinations for certain lower-risk procedures and patient populations. However, major open lung resections remain highly invasive thoracic operations associated with substantial perioperative risk and postoperative resource requirements. Patients undergoing open unilateral or bilateral lung resections frequently require chest tube management, serial imaging, respiratory therapy, intensive pain management, oxygen support, and close monitoring for significant complications, including prolonged air leak, pneumonia, postoperative bleeding, respiratory failure, bronchopleural fistula, and cardiac arrhythmias. Many of these complications may not become apparent immediately following surgery and may require a prompt hospital-based intervention.

In addition, Medicare beneficiaries undergoing these procedures often present with significant comorbidities, including chronic pulmonary disease, reduced pulmonary reserve, frailty, diabetes, renal dysfunction, and other conditions that increase the risk of adverse postoperative outcomes. While CMS cites advances in surgical care as justification for broad IPO list elimination, much of the evidence supporting accelerated recovery and earlier discharge is derived from minimally invasive procedures and selected patient populations rather than complex open thoracic procedures performed in the Medicare population. Published thoracic surgery literature continues to demonstrate substantial postoperative complication rates among older adults undergoing major pulmonary resections, including arrhythmias, prolonged air leak, pneumonia, respiratory compromise and other complications requiring hospital-based intervention and monitoring.[29,30,31,32] The agency has not addressed this evidence or provided other procedure-specific clinical evidence or Medicare beneficiary outcomes data that show removal can be accomplished without adversely affecting patient safety or quality of care.

Stomach Resection

- Proposed procedures/CPT codes:
    - 43620 – Removal of stomach
    - 43621 – Removal of stomach
    - 43622 – Removal of stomach

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[29] National Library of Medicine. (September 2021) “Enhanced recovery after thoracic surgery: Systematic review and meta-analysis.” https://pmc.ncbi.nlm.nih.gov/articles/PMC9390629/pdf/main.pdf
[30] European Journal of Cardio-Thoracic Surgery. (October 2018) “Guidelines for enhanced recovery after lung surgery: recommendations of the Enhanced Recovery After Surgery (ERAS®) Society and European Society of Thoracic Surgeons (ESTS).” https://academic.oup.com/ejcts/article/55/1/91/5124324
[31] The Society of Thoracic Surgeons. (March 2025) “Case Presentation: Thoracic Surgery General Management IV Complications.” https://learningcenter.sts.org/content/case-presentation-thoracic-surgery-general-management-iv-complications
[32] Journal of Thoracic Disease. (2021) “Pneumonectomy for lung cancer in the elderly: lessons learned from a multicenter study.” https://pmc.ncbi.nlm.nih.gov/articles/PMC8575851/pdf/jtd-13-10-5835.pdf

- These CPT codes are equivalent to the following ICD-10-PCS codes:
    - 0D13079 – Bypass lower esophagus to duodenum with autologous tissue substitute, open approach
    - 0DT60ZZ – Resection of stomach, open approach
    - 0D1307A – Bypass lower esophagus to jejunum with autologous tissue substitute, open approach

- Which group to the following MS-DRGs:
    - MS-DRG 326 – Stomach, esophageal and duodenal procedures with MCC
    - MS-DRG 327 – Stomach, esophageal and duodenal procedures with CC
    - MS-DRG 328 – Stomach, esophageal and duodenal procedures without CC/MCC

While the AHA recognizes that advances in surgical technique, anesthesia, perioperative management and enhanced recovery pathways have improved outcomes for selected patients undergoing gastric procedures, open gastrectomy remains a major, high-risk abdominal operation associated with substantial morbidity, reoperation, readmission and mortality risk. In an American College of Surgeons National Surgical Quality Improvement Program analysis of gastrectomy patients, 21.7% experienced a major complication, 7.9% required reoperation, and 30-day mortality was 5.2%, with increased risk associated with factors such as age, preoperative malnutrition and total gastrectomy. Additional population-level data continues to demonstrate clinically significant rates of postoperative complications, anastomotic leakage, reintervention and mortality after gastrectomy.

We are concerned that removal from the IPO list could be interpreted as signaling that open stomach resection may be routinely appropriate in the outpatient setting, despite the need for inpatient-level postoperative monitoring in many patients. Gastrectomy patients may require close monitoring for anastomotic leaks, bleeding, infection, ileus, dehydration, nutritional compromise, cardiopulmonary complications and the need for urgent reintervention. Readmission studies identify postoperative complications, total gastrectomy, combined organ resection and nutritional risk as important predictors of

readmission.[33,34,35] There are significant clinical risks associated with open stomach resection procedures, including major postoperative complications, nutritional compromise, reintervention and readmission, while there is limited evidence demonstrating safe outpatient management of these procedures in the Medicare population. To the best of our knowledge, the agency has not addressed these risks or provided other procedure-specific clinical evidence or Medicare beneficiary outcomes data that shows that removal can be accomplished without adversely affecting patient safety or quality of care.

Removal of Colon

- Proposed procedure/CPT code:
    - 44150 – Removal of colon
- These CPT codes are equivalent to the following ICD-10-PCS codes:
    - 0D1B0Z4 – Bypass ileum to cutaneous, open approach
    - 0D1B0ZP – Bypass Ileum to rectum, open approach
    - 0DTE0ZZ – Resection of large intestine, open approach
- Which group to the following MS-DRGs:
    - MS-DRG 329 – Major small and large bowel procedures with MCC
    - MS-DRG 330 – Major small and large bowel procedures with CC
    - MS-DRG 331 – Major small and large bowel procedures without CC/MCC

Although advances in minimally invasive colorectal surgery and Enhanced Recovery After Surgery protocols have improved outcomes and reduced length of stay for selected patients, those advances should not be extrapolated to open colectomy procedures. Open colon removal remains major abdominal surgery and is often performed for clinically complex conditions such as colorectal cancer, obstruction, inflammatory bowel disease, diverticulitis, ischemia, perforation or bleeding. Peer-reviewed studies continue to show meaningful risks of postoperative morbidity, including infection, ileus, anastomotic complications, sepsis, venous thromboembolism, reoperation, ostomy formation and mortality. National data also show that while

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[33] Morbidity and Mortality after gastrectomy: identification of modifiable risk factors https://pmc.ncbi.nlm.nih.gov/articles/PMC4987171/pdf/nihms800214.pdf
[34] Outcomes after gastrectomy according to the Gastrectomy Complications Consensus Group (GCCG) in the Dutch Upper GI Cancer Audit (DUCA) https://pmc.ncbi.nlm.nih.gov/articles/PMC11335793/pdf/10120_2024_Article_1527.pdf
[35] Risk factors of the postoperative 30-day readmission of gastric cancer surgery after discharge https://pmc.ncbi.nlm.nih.gov/articles/PMC6417637/pdf/medi-98-e14639.pdf

colectomy outcomes have improved over time, 30-day mortality remained unchanged at 1.7%, underscoring that these procedures continue to carry significant clinical risk.

From a quality and safety standpoint, open colon removal patients frequently require inpatient monitoring for return of bowel function, fluid status, pain control, wound complications, infection, bleeding, nutritional tolerance and early signs of anastomotic leak or intra-abdominal sepsis. While advances in minimally invasive colorectal surgery have improved outcomes for selected patients, peer-reviewed studies continue to demonstrate meaningful differences in postoperative outcomes between minimally invasive and open colorectal surgery. Systematic reviews and large observational studies have found that open colorectal procedures are associated with higher rates of postoperative morbidity, mortality, septic complications, wound complications, and longer hospital stays than minimally invasive approaches. These findings indicate that open colon resections remain clinically distinct procedures with greater postoperative risks and monitoring needs. Accordingly, outcomes reported in studies of minimally invasive colorectal surgery may not fully represent the clinical complexity and postoperative recovery considerations associated with major open colon removal procedures.[36]

These procedures continue to involve substantial clinical complexity, significant postoperative risks and a need for close inpatient monitoring that cannot be reliably addressed through outpatient care pathways. Performing them in an inpatient setting supports patient safety, preserves appropriate clinical decision-making and helps ensure that Medicare beneficiaries undergoing major open colon surgery receive care in the setting best aligned with their individual risk profile and postoperative needs.[37,38,39] Yet, the agency has not provided procedure-specific clinical evidence or Medicare beneficiary outcomes data that shows that removal can be accomplished without adversely affecting patient safety or quality of care.

Additional Procedures

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[36] Annals of Surgery Open. (September 2021) "Laparoscopic Versus Open Colorectal Surgery in the Emergency Setting: A Systematic Review and Meta-analysis." https://pmc.ncbi.nlm.nih.gov/articles/PMC10455067/pdf/as9-2-e097.pdf

[37] BioMed Research International. (September 2017) "The Impact of Frailty on Morbidity and Mortality following Open Emergent Colectomies." https://pmc.ncbi.nlm.nih.gov/articles/PMC5606101/pdf/BMRI2017-5126452.pdf

[38] Colorectal Disease. (2026) "Early post-operative outcomes in adults undergoing minimally invasive versus open emergency colorectal surgery: A retrospective cohort study of the ASC-NSQIP 2016 – 2022" https://onlinelibrary.wiley.com/doi/pdf/10.1111/codi.70481

[39] Updates Surg. (March 2019) "Laparoscopic versus open colectomy: the impact of frailty on outcomes." https://pubmed.ncbi.nlm.nih.gov/29663301/

In addition, AHA members contacted us with concerns about other procedures proposed for removal from the IPO list in 2027. Hospitals and health systems noted that the following procedures require code teams and inpatient recovery, and that their affected organs have a very strong blood supply and/or are blood filtration organs and therefore present a risk of bleeding out. They also note that these procedures are also proposed to be covered in an ASC in 2027. They say this would pose serious risks and have negative quality of care implications for vulnerable Medicare patients.

- CPT code 32100 – Major thoracotomy (open chest exploration), especially when this procedure is combined with:
    - CPT code 32097 – Open wedge biopsy of lung nodule
    - CPT code 39220 – Resection of mediastinal tumor (this procedure can be touching important aortas)
    - CPT code 32482 – Bi-lobectomy (this is the removal of two lung lobes and must be done with an open chest)

- CPT code 47120 – Partial removal of liver; CPT code 38101 – Partial removal of the spleen; CPT code 50240 – Partial removal of the kidney; CPT code 48140 – partial removal of the pancreas

We also have concerns about the 801 services that would remain on the IPO list in CY 2027, because CMS indicates they may be considered for removal in 2028. Specifically, there are some that our physician experts strongly believe would *never* be appropriate to furnish in an outpatient setting and certainly should not be removed from the list within the next two years. These include:

- CPT code 32853, Lung transplant, double (bilateral sequential or en bloc) and CPT code 32854, with cardiopulmonary bypass
- CPT code 33523, Coronary artery bypass, using venous graft(s) and arterial graft(s), six or more (Must be billed alongside an appropriate primary arterial grafting code (such as CPT code range 33533–33536)
- CPT code 33935, Transplantation heart/lung

We urge CMS to re-examine its IPO list, and ensure the above procedures remain designated as inpatient only.

APC Assignments

While CMS has proposed APC assignments for the 637 procedures identified for removal from the IPO list in 2027, we are concerned that it does not have the claims, cost or other needed data to *appropriately* determine the APCs in which they should be incorporated. Absent sufficient outpatient utilization, claims experience and hospital cost data, CMS may face challenges establishing outpatient PPS payment rates that

accurately reflect resource consumption, perioperative intensity and postoperative monitoring requirements.

Moreover, CMS acknowledges that many of the 801 procedures to be removed in the third year of the IPO list phase-out are more clinically complex and may require additional APC restructuring and review. Grouping these 801 procedure codes into APCs and creating new APCs where necessary will be a huge undertaking. These remaining two years is clearly not enough time to do this responsibly. In addition to clinical and patient safety considerations, which we have outlined, we remain steadfast in our recommendation that services should not be removed from the IPO list until there are adequate data available to create new or revised APCs and these APCs are established.

Financial and Administrative Burden

We are concerned about the financial and administrative burden of elimination of the IPO list over such a short period of time. For example:

- When a procedure is taken off the IPO list, healthier Medicare beneficiaries' care — and shorter length of stay — tends to migrate to the outpatient setting, leaving the sicker and more complex patients as inpatients. Eliminating the entire IPO list over these next two years would magnify this impact on hospital costs, which would come without a commensurate increase in reimbursement.
- CMS' policy would increase the complexity of billing and claims processing because determining the appropriate billing codes for these procedures on the IPO list over the next two years would not only require greater scrutiny, but also would be an overwhelming effort, likely leading to large numbers of payment denials or delays if not managed correctly.
- This policy results in downstream issues regarding Medicare coverage and reimbursement of post-acute care. For example, without a three-day inpatient hospital stay, Medicare beneficiaries who would have previously qualified for Medicare-covered skilled-nursing facility care would no longer qualify. AHA health system members that own skilled nursing facilities have indicated that many of the procedures proposed for elimination in CY 2027 would have a substantial impact on beneficiary access to post-acute care.[40,41,42]

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[40] Skilled Nursing News. (November 2025) "CMS: New Inpatient Procedures Rule Won't Hurt Skilled Nursing Facility Access." https://skillednursingnews.com/2025/11/cms-new-inpatient-procedures-rule-wont-hurt-skilled-nursing-facility-access/

[41] Leading Age. (July 2026) "CMS Proposes More Procedures Permitted as Outpatient." https://leadingage.org/cms-proposes-more-procedures-permitted-as-outpatient/

[42] Davis Wright Tremaine, LLC. (July 2026) "CMS Proposal May Increase Inpatient Admission Scrutiny for IPO-Removed Services." https://www.dwt.com/insights/2026/07/cms-ipo-list-proposal-reimbursement-scrutiny-cy-27

- The proposed removals may increase scrutiny of inpatient admissions by commercial and Medicare Advantage plans, which may rely on the elimination of IPO list status to argue that certain procedures should not be performed on an inpatient basis, even though CMS continues to state that removal from the IPO list does not require outpatient treatment in every case.[43]
- There would be increased administrative effort involved in ensuring appropriate clinical decision-making and potentially navigating disputes with payers regarding the chosen site of service.

If, despite the AHA's concerns, CMS decides to continue its phase-out of the IPO list, we recommend that additional steps be taken to minimize the patient safety and financial impact of this policy. First, CMS should provide clear guidance to physicians to help them determine which surgeries and procedures should be performed in an outpatient setting versus those that still qualify for inpatient, even if the case does not cross the two-midnight threshold. The AHA urges CMS to work with stakeholders, including physician specialty societies, to develop guidelines for the circumstances under which procedures removed from the IPO list may safely and appropriately be performed in outpatient settings versus inpatient settings. For example, CMS should work with stakeholders to identify peer-reviewed evidence to help physicians make such site-of-service determinations. One important resource we suggest CMS utilize is the American Society of Anesthesiologists' Physical Status Classification System.[44] This is a fundamental tool in perioperative medicine, providing healthcare professionals with a standardized method to assess and categorize patients' physiological status before surgery. The value of this system lies in its ability to help predict operative risk and guide clinical decision-making, although its application requires careful consideration of various patient factors and comorbidities.[45]

In addition, because the IPO list is both a financial and a beneficiary safety policy, we strongly recommend that CMS ensure that any policies related to removing procedures from the IPO list under traditional Medicare also be applied to MA plans. Specifically, it should explicitly require MA plans to continue to consider these procedures as covered inpatient services. AHA hospital and health system members tell us that often, when CMS removes procedures from the IPO list, MA plans adopt the policy as well, but Medicare's "option" for the outpatient setting becomes the MA plan's justification for making it the default location.

Finally, although CMS states that it will continue applying its existing policy of indefinitely exempting procedures removed from the IPO list from certain medical review activities related to the two-midnight policy, we believe that this medical review policy

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[43] Id.
[44] Anesthesiology Open. (April 2026) "American Society of Anesthesiologists Statement on ASA Physical Status Classification System." Statement on ASA Physical Status Classification System
[45] StatPearls. (February 2025) "American Society of Anesthesiologists Physical Status Classification System." https://www.ncbi.nlm.nih.gov/books/NBK441940/

should go further. That is, if a service is removed from the IPO list, CMS should require that this prohibition on medical review activities also apply to MA plans for an appropriate period during which the plan could not deny them as an inpatient service.

EXPANSION OF BOTULINUM TOXIN INJECTION CODES FOR HOPD PRIOR AUTHORIZATION PROCESS

For CY 2027, CMS proposes expanding its prior authorization requirements to apply to additional botulinum toxin injection codes. Specifically, CMS would add eight botulinum toxin injection Healthcare Common Procedure Coding System (HCPCS) codes, effective for services furnished on or after July 1, 2027.

The AHA appreciates CMS' efforts to ensure that Medicare pays appropriately for covered outpatient services. **However, CMS' proposal would affect codes that are predominately medical, not cosmetic, in nature. As such, we are concerned that CMS' proposal would create inappropriate barriers to care for patients who rely on these critical treatments.** Specifically, the proposed codes describe chemodenervation of the salivary glands, neck muscles, larynx, extremity muscles and trunk muscles.[46] These procedures are commonly used to manage clinically significant neurologic, neuromuscular, voice, salivary and spasticity-related conditions, including sialorrhea, cervical dystonia, spasmodic dysphonia and limb or trunk spasticity.[47,48,49] They often involve patients with chronic neurologic or disabling functional conditions who require individualized, recurring treatment. For these patients, any delays in treatment may have tangible clinical consequences, including worsening pain or dystonic posturing, muscle tightening/spasms, impaired mobility or positioning, difficulty with hygiene and caregiving, worsening speech impairment, excessive salivation, and potential swallowing or aspiration-related concerns.

In setting forth its proposal, CMS states that utilization for the proposed codes increased more rapidly than overall HOPD utilization from 2017 through 2024 and concludes that this pattern supports prior authorization. **However, the agency should not rely primarily on aggregate utilization growth to conclude that use is unnecessary.** Indeed, CMS itself acknowledges that expanded Food and Drug

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[46] Chemodenervation is a medical procedure that uses a chemical agent, most commonly botulinum toxin, to block nerve signals to a specific muscle or muscle group, causing temporary relaxation and reduced muscle activity.
[47] Cochrane Database of Systematic Reviews. (2020) "Botulinum toxin type A therapy for cervical dystonia." https://pmc.ncbi.nlm.nih.gov/articles/PMC8106615/pdf/CD003633.pdf
[48] Neurology. (2015) "Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache." https://pmc.ncbi.nlm.nih.gov/articles/PMC4862245/pdf/NEUROLOGY2015672790.pdf
[49] J Neural Transm. (February 2021) "Consensus guidelines for botulinum toxin therapy: general algorithms and dosing tables for dystonia and spasticity." https://pmc.ncbi.nlm.nih.gov/articles/PMC7969540/

Administration (FDA)-approved indications, such as for chronic sialorrhea and spasticity, may have contributed to utilization growth. In addition, broader adoption of botulinum toxin in rehabilitation and movement-disorder care and rebound in services following COVID-19-related care delays contributed towards this growth. Yet, CMS does not provide diagnosis-level utilization, specialty-level utilization, geographic trends, medical review findings, denial rates, comprehensive error rate testing or OIG findings, or other evidence demonstrating that the identified claims reflect inappropriate or unnecessary care.

As such, the AHA urges CMS to withdraw its proposed expansion of prior authorization to the eight additional botulinum toxin injection codes. If CMS nevertheless proceeds, it should substantially narrow the policy and include safeguards to prevent delays in medically necessary treatment for patients with neurologic, neuromuscular, salivary, voice and spasticity-related disorders. CMS should also publish more granular data supporting its conclusion that observed utilization increases reflect unnecessary care, distinguish normal clinical adoption and coding/product changes from inappropriate utilization, and monitor the policy for unintended effects on access, treatment continuity, appeals and beneficiary outcomes.

Specifically, if the agency moves forward, prior authorization safeguards are needed to avoid treatment interruptions for established patients. These should include an expedited renewal process for patients with documented prior response, authorization periods that align with clinically appropriate repeat-treatment intervals, clear criteria for urgent or time-sensitive review, provider education prior to implementation, and a CMS process to monitor denials, appeals, treatment delays and beneficiary complaints after implementation. Botulinum toxin therapy is frequently delivered as part of an ongoing treatment plan, with dosing, muscle selection, injection technique and treatment interval titrated to the individual patient. Clinical literature emphasizes that botulinum toxin therapy is highly individualized and depends on selecting the appropriate target muscles and doses.[50,51,52] Prior authorization processes that delay repeat injections could disrupt a stable regimen, allowing symptoms to recur and increasing the risk of functional decline or avoidable

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[50] Neural Transm. (March 2021) “Consensus guidelines for botulinum toxin therapy: general algorithms and dosing tables for dystonia and spasticity.” https://pubmed.ncbi.nlm.nih.gov/33635442/
[51] Toxins. (November 2023) “Selecting Goals and Target Muscles for Botulinum Toxin A Injection Using the Goal Oriented Facilitated Approach to Spasticity Treatment (GO-FAST) Tool.” https://pmc.ncbi.nlm.nih.gov/articles/PMC10748217/
[52] Toxins. (June 2026) “Botulinum Toxin Type A in Spasticity and Cervical Dystonia: Practical Clinical Recommendations from a Mexican Multidisciplinary Panel of Specialist Injectors.” https://www.mdpi.com/2072-6651/18/7/287

complications. [53, 54] For example, interruption of therapy for cervical dystonia can contribute to worsening painful neck posturing, while delay in laryngeal chemodenervation may affect voice function in patients with spasmodic dysphonia.

The AHA understands that CMS' prior authorization program does allow expedited/urgent requests to be evaluated within two business days, but it lacks granular, codified pathways tailored specifically to repeat-treatment intervals or documented historical responses. In addition, rather than exempting prior authorization for patients based on clinical history, CMS only grants a provider-level exemption if the HOPD achieves a provisional affirmation rate of at least 90% over a designated evaluation period. However, these options do not address the concerns we mention above.

We also urge CMS to consider alternative policies, such as:

- Limiting prior authorization to specific diagnoses or utilization patterns for which CMS can demonstrate an actual risk of inappropriate utilization, rather than applying it broadly to medically necessary neurologic and functional indications.
- Excluding patients with an established course of therapy and documented clinical benefit from repeated prior authorization requirements.
- Implementing targeted post-payment or pre-payment medical review for outlier billing patterns rather than requiring prior authorization for all providers and all covered indications.
- Publishing detailed medical necessity criteria, documentation expectations, expected response timeframes and appeal processes before implementation.
- Delaying implementation if CMS cannot provide diagnosis-level and product-specific analyses supporting the conclusion that increased utilization is unnecessary.

CODIFICATION OF SECTION 6225 OF THE CONSOLIDATED APPROPRIATIONS ACT, 2026 FOR THE REQUIREMENTS FOR PROVIDER-BASED STATUS

Background

CMS proposes to codify the provisions in Section 6225 of the Consolidated Appropriations Act of 2026, which prohibit Medicare payments for excepted and non-

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[53] The American Journal of Managed Care. (April 2025) "Prior Authorizations and the Adverse Impact on Continuity of Care." https://www.ajmc.com/view/prior-authorizations-and-the-adverse-impact-on-continuity-of-care

[54] National Public Radio. (February 2026) "Can't get a prescription renewed? Here's how to cope with prior authorizations." https://www.npr.org/2026/02/26/nx-s1-5711632/prior-authorizations-expiration-prescription-insurance

excepted off-campus outpatient departments of a provider, beginning Jan. 1, 2028, unless they bill using a separate NPI and the main provider has submitted an attestation that the off-campus outpatient department of a provider meets the requirements of the provider-based rules. An initial attestation is required during the two-year period ending on the date such items and services are furnished. A subsequent attestation is required within a timeframe specified by the secretary.

In a March 24 letter to CMS, the AHA raised concerns about the significant burden that Section 6225's requirements would entail, not only for hospitals and health systems, but also for Medicare's contractors. Many of our members, who have previously attempted to voluntarily submit attestations for their off-campus outpatient departments, had to do so across several Medicare Administrative Contractors (MACs). They stated that the existing process for attesting varies a great deal across MACs and often takes an inordinately long time due to miscellaneous and repeated requests for additional supporting documentation, which increases provider burden tremendously.

We thank CMS for incorporating several of our recommendations to reduce burden for the initial and subsequent attestation process, as discussed below. However, we continue to have concerns related to the separate NPI requirement, discussed below.

Attestations

Initial Attestations. CMS proposes that initial attestations must be submitted from Jan. 1, 2026, through Dec. 31, 2027, for off-campus outpatient departments for items and services furnished before Jan 1, 2028. Further, for off-campus outpatient departments where items and services are first furnished on or after Jan. 1, 2028, CMS would require initial attestations to be submitted within two years prior to the date that the items and services were furnished. CMS proposes that subsequent attestations be submitted at an interval to be specified by CMS and not to exceed five years after the initial attestations.

The AHA supports CMS' proposal that submitting an attestation of compliance for an off-campus department prior to Jan. 1, 2028, regardless of whether a determination by CMS has been made by that date, would satisfy the new statutory requirement for an initial attestation.

The agency also is considering allowing a CMS provider-based status determination made before Jan. 1, 2026, to satisfy the initial mandatory attestation requirement, provided the department has remained in compliance with all applicable provider-based regulations. In these circumstances, CMS would require the authorized official to submit a letter attesting to continued compliance, along with evidence of CMS' prior determination. **The AHA supports this proposal and urges CMS to finalize it.**

Standardized Attestation Form and Process. The AHA strongly supports CMS' proposal to replace the current paper-based MAC-specific attestation templates with a standardized attestation form that would be submitted via a centralized

electronic system. This would address concerns raised in our March 24 letter regarding the complications and burden involved with the current system of multiple MAC processes for attestation. While we also support CMS' proposal indicating that, until the standardized form and centralized electronic system are finalized, providers may continue to submit attestations using the current process, the AHA urges CMS to quickly finalize the online form and the updated centralized electronic system for submission of attestations to reduce the burden on providers, CMS and its MACs.

Under the current attestation process, providers must submit their attestations and supporting documentation to their MACs, which perform a preliminary review and forward a recommendation to CMS for its initial determination. This process is often burdensome and results in multiple delays and redundant requests from the MAC. **Therefore, the AHA supports CMS' proposal to modify this process so that the MACs conduct standardized review and validation activities in support of initial determination rather than requiring separate CMS review of each attestation recommendation.** We understand and support the notion that this process could include automated validation activities, data analysis, targeted documentation review and contractor review procedures designed to support consistent national implementation and program integrity oversight.

The AHA also supports CMS' proposal that the MAC would provide written acknowledgment of receipt to the provider, review its attestation for completeness and consistency, and determine whether the facility or organization is provider-based — and that this determination would constitute the initial determination for purposes of Sec. 6225.

In addition, the AHA strongly supports CMS' proposal to adopt a policy applicable for providers that must submit attestations for more than one off-campus outpatient department. Specifically, the agency's policy would: (1) allow streamlined supporting documentation to be submitted to minimize burden and (2) leverage its system capabilities to reduce duplicative documentation submissions by allowing providers to submit supporting documentation applicable to multiple locations a single time. Many hospitals and health systems have numerous off-campus departments, and allowing such batching of attestations would tremendously reduce burden and expedite the process of validating their provider-based status.

Subsequent Attestations. CMS proposes that, as of Jan. 1, 2028, a main provider must have submitted an initial attestation of provider-based status for each of its off-campus outpatient departments and *that subsequent attestation(s) be submitted within a period not to exceed five years thereafter.* The agency anticipates addressing the subsequent attestation requirement in the 2028 rulemaking cycle but nonetheless is still accepting comments on the subsequent attestation currently.

The AHA supports CMS' proposal that a main provider would be required to submit a subsequent attestation for each of its off-campus outpatient departments within a period not to exceed five years after its initial attestation(s).

As such, we urge CMS to:

- Require only one subsequent attestation that should be submitted within five years after the initial attestation was submitted. This is consistent with the provisions of Sec. 6225, which mandates only "an initial and subsequent attestation."
- Allow a provider, particularly those with many off-campus departments, to submit each of their off-campus departments' subsequent attestations in a time-staggered manner within the confines of "within five years" to avoid overburdening such providers and their MACs.
- Consider, if it opts to require periodic re-attestations, only requiring these to occur in specified circumstances already described in the current provider-based regulations, such as when there is a material change in the relationship between the hospital and its off-campus PBD, such as a change in ownership or a management contract change.
- Establish the same standard submission and approval process across all its MACs and regional offices that would apply to both the initial and the subsequent attestation.

Draft Standardized Attestation Form. CMS states that once the standardized attestation form and centralized electronic system are finalized, providers would need to submit a completed attestation, signed and dated by an authorized official (AO) of the main provider as identified in the Provider Enrollment, Chain, and Ownership System. The attestation would be required to identify both the main provider and the off-campus outpatient department of the provider for which provider-based status is sought, including the applicable NPI, address and the date on which provider-based conditions were met or the date the department was acquired.

The AHA appreciates that CMS has posted its draft attestation form for comments. Overall, we support the layout and contents of this draft form, particularly because it would replace the old, fragmented MAC templates with a unified electronic layout and includes individual yes, no and not applicable checkbox affirmations for each of the provider-based regulatory requirements. However, hospitals and health systems often have many — sometimes hundreds — of off-campus departments. Requiring that their AO complete, personally sign and submit each of these attestations would be cumbersome and time-consuming. As such, we recommend that:

- CMS permit the AO to submit an electronic signature in lieu of an original ink signature, along with the AO's name, title, direct telephone number and date.
- CMS allow the AO of the provider to identify one or more "submitters" who are granted permission to submit the attestation form(s) on behalf of the AO. This

could be operationalized by adding a checkbox to the draft attestation form indicating that a submitter has been granted the authority by the AO to submit the completed form and upload all supporting documentation to CMS, as well as including a place for the submitter to insert their name and electronic signature.

CMS Verification and Oversight Activities. Under the law, CMS must establish a process for determining compliance with the above requirements and the provider-based rules. As such, the agency proposes a process that involves initial reviews, targeted reviews and extended reviews. The AHA supports the need for such reviews. However, we urge the agency to use its discretion if it uncovers inadvertent and minor errors or omissions — for instance, if an address listed "Road" instead of "Rd" or a box was inadvertently left unchecked in the attestation form. **In these circumstances, we request that the MAC/CMS contact the provider to correct the inadvertent oversight or error, which should not result in a determination of elevated compliance risk.**

Separate NPIs

Under Sec. 6225, beginning Jan. 1, 2028, each off-campus outpatient department will be required to obtain and bill under its own NPI. While the AHA understands that Congress has mandated this change, the separate NPI requirement raises significant concerns and will substantially and negatively impact hospitals and health systems, as well as their patients. To prevent unnecessary delays in payment and unneeded patient billing confusion, we encourage CMS to adjust implementation requirements, exercise enforcement discretion and issue additional guidance to ensure the industry is adequately prepared. Specifically, at a minimum, CMS should:

- Exercise enforcement discretion during a reasonable transition period of at least 12 months.
- Create a standardized mechanism that links each off-campus NPI to the hospital's main-campus NPI. This crosswalk should be made available to Medicare contractors and other payers so that systems can recognize the same hospital organization.
- Address claims fragmentation and prior authorization issues created by this policy.
- Establish a phased-in and transparent implementation process.
- Provide sufficient time for provider enrollment, payer configuration and end-to-end testing.
- Convene stakeholders to identify and resolve claims processing issues.

Inconsistent NPI Application Across Insurers. The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions were created to eliminate idiosyncratic plan requirements for processing healthcare revenue transactions. As part of this initiative, Congress mandated that providers obtain a single identification method — the NPI – for use across all claims, regardless of the insurer.

The standardization of revenue cycle transactions saves an estimated $258 billion in administrative waste annually.[55] Yet, the current proposal to require distinct NPIs for off-campus outpatient departments of a provider for use with Medicare significantly undercuts these efforts, as it will now require providers to utilize a different NPI for CMS than it does for other payers with whom they have agreed to utilize the main campus NPI.

To mitigate these problems, we urge CMS to exercise enforcement discretion for at least 12 months, during which time providers utilizing a central billing NPI could continue to use existing methods of reporting services delivered at off-campus PBDs while making any adjustments with other payers to ensure consistent billing practices. Additionally, CMS should work with other federal and state regulators, health plans, clearinghouses and standards development organizations to promote consistent treatment across payers. The agency should also provide its contractors and other payers with a crosswalk between each off-campus outpatient department NPI and its associated hospital NPI.

Coordination of Benefits. When Medicare is the primary payer on a claim using the newly issued NPI, subsequent payers will be unable to process the claim it receives from Medicare, as the NPIs will not match. This will create an unneeded denial, requiring providers to address via appeals and an unnecessary obstruction to patients receiving proper coverage benefits and post-care financial statements. **To mitigate this, CMS should ensure that Medicare crossover claims and remittance information include the data needed to associate the new off-campus department NPI with the hospital's main-campus NPI. This information should be made available to Medicare contractors and other payers so that systems can recognize the same hospital organization. Additionally, the AHA recommends that CMS test such transactions with coordination of benefits vendors and secondary payers before the effective date and publish instructions for resolving NPI mismatches without requiring hospitals or patients to initiate appeals.**

Professional Claims. Although the statutory requirement is directed at HOPDs, requiring a new NPI for an off-campus HOPD would potentially interfere with physicians' and other healthcare professionals' claims submitted using the HIPAA standard professional claim (X12 837P). To report a service location that differs from their billing address, these providers report the type-2 NPI of the facility in the 2310 Loop of their claim. Changing this NPI for CMS would necessitate that submitters also update their billing processes to ensure that they are properly identifying the facility. This alone will be a significant administrative update for physicians, but it will be amplified by needing to differentiate according to the specific payer with whom they are interacting. Additionally,

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[55] DataSpring. (February 2026) "CAQH Index Shows U.S. Healthcare Avoided $258 Billion and Accelerated Automation, Interoperability and AI Adoption." https://www.dataspring.com/blog/2025-caqh-index-shows-u.s.-healthcare-avoided-258-billion-and-accelerated-automation-interoperability-and-ai-adoption

such a disruptive change would require hospitals to educate physicians on these new procedures, further adding to the administrative complexity and burden that this requirement would place upon hospitals and health systems. **Accordingly, we recommend that CMS enable providers using the 837P claim to report either the new HOPD NPI or the main campus NPI when indicating a service location other than their billing address. This would prevent disruption in the claims processing and would not diminish the ability to identify the type of facility in which care is delivered (which can be determined using the place of service code).**

Billing for Services Spanning Different Locations. To reduce the total number of claims and consolidate patient bills, hospitals routinely bill for multiple services on the same claim, including those that occur at different locations within the hospital. The proposed rule jeopardizes the ability for hospitals to continue this practice, as the new NPI requirements cannot currently be combined into a single claim. The HIPAA standard institutional claim (X12 837I) does not facilitate or permit the reporting of an NPI at the service-line level. As a result, a patient whose treatment spans both a main campus facility and an off-campus clinic would receive multiple separate claims for their care, which may increase confusion and potentially impact out-of-pocket costs. **CMS should clarify, through rulemaking or claims-processing guidance, whether and how hospitals may continue to consolidate services when care spans locations with different NPIs. If separate claims are unavoidable, it should adopt billing instructions that preserve appropriate claim linkage and episode-of-care information, minimize duplicate edits and patient cost-sharing errors, and prevent the issuance of multiple confusing patient statements. CMS also should work with standards-development organizations on a longer-term solution that can accurately represent services furnished across locations without unnecessary claims fragmentation.**

Prior Authorization. Prior authorization is a resource-intensive process that requires advanced plan approval of treatment before it can be administered. The AHA has pushed for systematic reform of this process for years, and we are encouraged by the numerous CMS and HHS initiatives designed to reduce provider and patient strain created by the process. Unfortunately, the proposed rule may significantly increase these difficulties by requiring multiple prior authorizations for the same course of patient care. Prior authorization is typically tied to the provider's billing NPI, meaning that an approved authorization would apply to claims originating from the NPI of the requesting facility. Currently, hospitals can obtain prior authorization for care under their central billing NPI, then permit the patient to seek the authorized services at the location of their choice. This is particularly helpful for patients receiving a course of multiple treatments, where certain locations may be more suitable or convenient for patients than others. Under the current proposal, a provider may need to request and obtain separate authorizations for each location to prevent coverage denials for necessary care. **The AHA encourages CMS to issue additional guidance to providers and health insurers to prevent this needless amplification of administrative difficulty and potential delays in patient care**. **We would be pleased to work with CMS as it**

develops such guidance. We also urge it to require MA and other CMS-regulated plans to recognize an approved authorization across affiliated hospitals and off-campus department NPIs when the service, ordering provider and course of treatment remain unchanged. At a minimum, CMS should direct plans to offer a streamlined process for transferring or associating an existing authorization with a newly assigned department NPI without requiring a new authorization. CMS also should incorporate the hospital-to-department NPI crosswalk into applicable prior authorization systems, establish clear denial protections during the transition and urge other health insurers to adopt the same approach.

Definition of a PBD in Certain Circumstances

Certain hospitals operate off-campus locations containing multiple offices that provide a variety of outpatient services. As such, we encourage CMS to issue guidance promoting operational flexibility by allowing hospitals and health systems to have the option to obtain a single NPI and submit a single initial attestation for the entire off-campus location. This would help reduce administrative complexities associated with these new requirements, while still ensuring that such off-campus locations are clearly reported as separate from the hospital's main campus.

APC ASSIGNMENT AND PAYMENT FOR RADIATION TREATMENT DELIVERY SERVICES: CPT CODES 77402, 77407 AND 77412

The AHA appreciates that CMS' CY 2027 Addendum B proposes increased payment rates for CPT codes 77402, 77407 and 77412. However, we remain concerned that the proposed APC assignment for CPT code 77407 to APC 5622 and the continued assignment of CPT code 77412 to APC 5623 undervalues intermediate and higher-complexity radiation treatment delivery services, particularly given the revised CPT code family and the bundling of imaging into these codes.

The AHA continues to recommend that CMS assign CPT code 77407 to APC 5623 and further consider assigning CPT code 77412 to APC 5624, as APC 5624 may more appropriately reflect the resource intensity of the highest-complexity radiation treatment delivery services. These assignments would better align outpatient PPS payment with clinical complexity, bundled imaging and resource costs associated with these services and help ensure continued beneficiary access to complex radiation oncology services furnished in hospital outpatient departments.

Assignment of CPT code 77407 to APC 5623 would also be consistent with CMS' longstanding payment treatment of predecessor Intensity-Modulated Radiation Therapy (IMRT) delivery services that historically were recognized in APC 5623 and whose imaging components are now incorporated into the revised code family. As the AHA noted in its CY 2026 outpatient PPS comments, the CPT Editorial Panel revised CPT codes 77402, 77407 and 77412 to establish a technique-agnostic family of codes and bundle imaging into these services, while deleting CPT codes 77385, 77386 and 77014.

Because the revised code family was specifically designed to consolidate and incorporate services previously reported through separate IMRT and imaging codes, CMS should ensure that payment for the revised codes appropriately reflects the resources associated with those previously separately recognized services.

We further noted that the deleted IMRT delivery codes CPT codes 77385 and 77386 historically were assigned to APC 5623. Accordingly, assigning the revised radiation treatment delivery codes to lower-level APCs may create a disconnect between the clinical and resource costs reflected in the revised code descriptors and the payment levels available under the outpatient PPS.

Therefore, the AHA urges CMS to reevaluate the proposed APC assignments for CPT codes 77407 and 77412 to ensure that payment appropriately reflects the clinical complexity, bundled service components and resource costs associated with furnishing these services. Such revisions would better align payment policy with the intent of the revised CPT code structure and CMS' longstanding treatment of comparable radiation treatment delivery services.

PAYMENT FOR SOFTWARE AS A MEDICAL SERVICE

The AHA appreciates CMS' ongoing efforts to update reimbursement methodologies for technology enabled services, especially as technologies like artificial intelligence continue to evolve. We directionally support CMS' proposal to establish an interim payment approach for Software as a Medical Service (SaMS) while it develops a more comprehensive long-term payment methodology. We also support CMS' proposal to maintain existing payment assignments during this transition period to help avoid disruptions in beneficiary access to these emerging technologies.

However, CMS can strengthen its proposed policies by:

- Clarifying the agency's intent in changing the name of Software as a Service (SaaS) to SaMS and describing how the agency will distinguish between clinical and non-clinical SaMS applications.
- Considering additional factors for future payment methodologies such as clinical time for validation and cybersecurity activities.

Below are our specific recommendations.

Recommend Additional Guidance on Terminology

In the proposed rule, CMS proposes to change terminology from SaaS to SaMS. The agency asserts that in fields other than healthcare, SaaS terminology is used for general cloud-based computing service models, which may cause confusion. The agency further states that the revised SaMS terminology would refer to software-based

technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality.

While we appreciate the intent to avoid confusion in terminology used by other industries, we urge CMS to provide further clarity regarding the proposed transition from SaaS to SaMS. Although CMS states that the terms are interchangeable, the agency is simultaneously introducing new terminology, a new status indicator (O1) and a transitional payment framework intended to support the development of future payment policies. As a result, stakeholders may reasonably question whether the terminology change represents more than a simple nomenclature update. We encourage CMS to clarify whether the transition to SaMS is intended solely as a naming convention or whether it reflects broader distinctions regarding the scope, classification, valuation or payment treatment of these technologies. Greater clarity is essential for hospitals and health systems making long-term technology investment decisions.

We also encourage CMS to provide additional guidance regarding how it intends to distinguish software that directly supports clinical decision making from software that incorporates broader operational, administrative or business functions. Many healthcare software platforms include both clinical and non-clinical capabilities, and the proposed rule does not clearly explain how these hybrid technologies will be evaluated within a future SaMS framework.

Recommended Factors to Consider when Setting Future Payment Rates

As CMS develops a permanent payment methodology, we urge the agency to consider the full range of costs hospitals incur to acquire, implement, integrate, maintain, update, validate and support these technologies. In addition to software licensing and storage, hospitals must devote significant resources to technology infrastructure, system integration, workforce training, ongoing maintenance, algorithmic analysis and cybersecurity. We reiterate previous comments we have made that these input costs must be considered in future payment methodologies.

For example, reimbursement models must account for clinical time used for validation and maintenance activities. AI-enabled tools are used to augment — not replace — human capacity. In fact, these tools still require a significant amount of human direction, such as when developing treatment plans and supervising outcomes. For example, while an AI-enabled tool may recommend a particular course of treatment, a clinician ultimately makes the final decision in consultation with patients and their caregivers. Reimbursement should account for the time required to validate AI outputs.

We also urge CMS to consider the substantial costs of cybersecurity activities needed to safely implement SaMS. Vendor risk assessments, vulnerability management, software updates, system monitoring and protection against evolving threats represent substantial and continuing costs that are necessary to safely deploy and maintain software-based medical technologies. Furthermore, cybersecurity premiums continue to

rise, outpacing reimbursement updates due to the increasing frequency and severity of cyberattacks. We encourage CMS to recognize these operational and cybersecurity costs when developing future SaMS payment policies and to provide stakeholders with additional opportunities for input before finalizing a permanent payment framework.

Finally, the budget-neutral aspect of payment increases has meant that increases in certain services have resulted in cuts in others. While we support "rightsizing" payment for technology enabled services, this should not come at the expense of other services.

OUTPATIENT QUALITY REPORTING PROGRAM

Proposed Removal of Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients Measure

Beginning with the CY 2027 reporting period (affecting CY 2029 payment), CMS proposes to remove this measure that assesses the percentage of patients 45-75 receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. The agency reasons that the measure is inadequate because it only determines whether the follow-up interval is documented rather than whether appropriate clinical care was delivered.

The AHA greatly appreciates CMS' recognition of the importance of striking an appropriate balance of burden and value in quality measurement programs and supports the removal of this measure from the OQR. The AHA has long advocated that all federal quality reporting and value programs use "measures that matter" — that is, measures that are focused on the highest priority areas for quality improvement, are feasible to collect and report, and whose value outweighs their burden. We agree that this process measure does not meet these criteria. Streamlining the number of measures in federal quality reporting programs can help hospitals focus their resources on high-priority and quality issues that matter most to their organizations.

Proposed Updates to OQR Data Validation

CMS proposes multiple changes to its data validation processes, including newly validating electronic clinical quality measures (eCQMs) and chart-abstracted clinical process of care measures, as well as streamlining certain previously established processes.

As HOPDs will be required to report data for an eCQM beginning with the CY 2027 reporting period and additional eCQMs in later reporting years, CMS proposes to incorporate validation of these measures into the existing OQR data validation process. This would entail applying the same file submissions policies and scoring methodology, although CMS proposes that hospitals would receive separate validation scores for

chart-abstracted measure data and for eCQM data. **The AHA supports this approach to introducing validation for eCQMs into the OQR, as it balances administrative simplicity while acknowledging that eCQMs and the data that inform them are different in nature from chart-abstracted measures.**

In addition, CMS proposes to update its process for selecting hospitals for data validation. Currently, CMS selects a random sample of 450 hospitals and an additional sample of 50 hospitals that meet certain targeting criteria (including previously failing validation, outlier values, previously low confidence intervals or missing quarters of data due to an extraordinary circumstance exception). The agency has found that hospitals in the random sample generally have high accuracy rates, and thus they can sample fewer hospitals randomly and more using the targeted approach (but fewer hospitals overall) and still be able to assess the accuracy of the data. Therefore, CMS proposes that, beginning with validation affecting CY 2030 payments, they would randomly select just 200 hospitals and then target an additional 200 hospitals for validation. **The AHA supports this approach, as it would result in lower unnecessary burden for additional hospitals and improve the usefulness of the validation process.**

Finally, CMS notes that the transition to all-electronic submission of materials (e.g., medical records) for validation obviates the need for hospitals to resubmit copies of materials when they request reconsideration of their validation outcomes. Thus, CMS proposes to formally remove the requirement of material resubmission. **The AHA supports this proposal and appreciates that CMS is actively identifying areas to streamline regulatory requirements.**

Request for Information: Advance Care Planning eCQM

The Advance Care Planning (ACP) eCQM was adopted in the Inpatient Quality Reporting program in the FY 2027 inpatient prospective payment system final rule. The measure reflects the proportion of adult patients with at least one inpatient hospitalization during the measurement period who have an ACP document or documentation of an ACP discussion resulting in a documented decision in the patient's electronic health record (EHR) by the time of hospital discharge. Citing the increasing volume of procedures shifting from the inpatient to the outpatient setting, CMS requests feedback on whether this measure is appropriate for use in the hospital outpatient setting, with or without modifications.

The AHA recognizes that advanced care planning is an important part of ensuring that the care patients receive aligns with their goals and values. However, we raised concerns about the feasibility of reporting this measure on the inpatient side — a setting for which it was designed and tested — and it is unclear whether those issues will be addressed before the measure is put into use; these issues would be compounded if the measure were used in the OQR.

When this measure was reviewed by the Hospital Workgroup of the Pre-Rulemaking Measure Review (PRMR) process, the committee raised multiple concerns about the measure's feasibility. These issues include a lack of structured fields to capture the ACP information in some EHRs; inconsistent documentation of codes for ACP discussions; and the lack of structured fields for some standalone items (such as goals, preferences and priorities). In the proposed rule, CMS notes that "[t]he eCQM underwent extensive analysis and measure specifications development required for the endorsement process. Test results indicated high measure reliability and validity (including agreement between data exported from the EHR and manual review of the patient chart)." However, the measure has not gone through the Consensus-based Entity (CBE) endorsement process yet, and it appears from the measure developer's feasibility analysis that the measure was only tested on two EHRs: three Epic systems and one Cerner system. Absent additional analysis, it is not clear whether the feasibility concerns raised during the PRMR have been addressed; considering the lack of experience with eCQMs in the OQR, feasibility is a major concern.

In addition, the measure's focus may not be appropriate for the OQR. It's true that many procedures are shifting from the inpatient to the outpatient setting, and it is important to ensure ACP discussions and documents are updated in certain episodes; however, the OQR assesses the quality of care provided in a much wider scope of services, not all of which would provide an appropriate opportunity for ACP. If CMS is intent on using the ACP measure in the OQR, we urge CMS to consider narrowing the denominator to focus on patients receiving more comprehensive care in HOPDs. CMS used a similar approach in the social driver of health screening measure it removed from the OQR last year. In commenting on that measure, the AHA suggested that some HOPD services, such as imaging or lab services or a diagnostic procedure ordered by a primary care physician with whom the patient has an existing relationship, would not be interactions adequate for performing this screening. CMS agreed, and in the CY 2025 outpatient PPS final rule clarified that the denominator cohort would not include patients receiving services limited to specific medical tests and rather would focus on patients who receive "more comprehensive care." We believe these circumstances apply to the consideration of the ACP measure in the OQR as well.

In a similar vein, we anticipate that there will be significant overlap in populations between patients served in the HOPD and inpatient settings. Without careful implementation, patients who have interactions in both settings may have duplicative or even conflicting ACP documentation. Regarding the same social drivers screening measure, CMS noted in the final rule that ambulatory facilities could simply confirm the status of any previously reported health-related social needs from another care setting rather than performing a unique screening. CMS could consider using a similar approach for implementing the ACP measure in the OQR. However, confirming the presence of an ACP document or discussion could be impossible if a patient were not seen within the same health system, especially given the concerns raised above about consistent capture of ACP documentation in EHRs.

Finally, while we recognize that CMS is not required to only use measures endorsed by a CBE, the CBE process may provide clarity on the issues raised above and would be critical to ensuring that measure reporting does not result in duplicative or discordant data collection, with multiple versions of advanced care plans existing across different entities and providers. Thus, we urge CMS to submit the measure for CBE endorsement review before considering it for adoption in the OQR.

ASC PAYMENT SYSTEM UPDATE

For CYs 2019-2023, CMS adopted a policy to update the ASC payment system using the hospital market basket update. The agency subsequently extended this policy through CY 2026. For CY 2027, CMS again proposes to use the hospital market basket update as the update factor for the ASC payment system. **The AHA remains opposed to this policy and CMS' proposal to extend it through CY 2027.** Medicare payment should reflect providers' underlying costs and patients served. Hospitals and ASCs have different costs and serve different patients. As such, it is inappropriate to use the hospital market basket to update payments for ASCs. **We instead recommend that CMS work expeditiously with ASC stakeholders to develop and implement a minimally burdensome way to collect ASC costs that could then be used to calculate an appropriate update mechanism**.

We are not alone in our continued concern in this area. MedPAC has, since 2010, recommended that CMS collect ASC costs. In its March 2026 report, it states "… the Commission has asserted that the cost structures of ASCs and HOPDs are likely very different" and "The Commission recognizes that ASCs are small facilities, but we have contended that it is feasible for ASCs to provide cost information. Small businesses like ASCs typically keep records of their costs for filing taxes and other purposes. In addition, all other facility providers submit cost data to CMS, including other small facilities such as rural health clinics, home health agencies, and hospices."[56] MedPAC has also repeatedly suggested several streamlined cost-collection processes that could be used to determine an appropriate input price index for ASCs, which CMS should consider.

ASC CPL

In the CY 2026 OPPS/ASC final rule, CMS revised the criteria used to evaluate potential additions to the ASC Covered Procedures List (CPL) by modifying the general standard criteria, as well as eliminating five of the general exclusion criteria and moving them into a new section as *nonbinding* physician considerations for patient safety. CMS

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[56] MedPAC. (March 2026) "Report to Congress." p. 337-338. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf

stated that these "safeguards," combined with appropriate patient selection and physician judgment, ensure only safely performed ambulatory procedures are included on the CPL. The agency also stated that this approach promotes physician and patient choice and supports site-neutral care, without compromising safety. Using these revised criteria, CMS proposes adding 618 procedures to the ASC CPL based largely on the agency's concurrent proposal to remove those same procedures from the IPO list.

The AHA continues to be concerned by the sweeping changes CMS made in 2026 to the process and criteria for adding surgical procedures to the ASC CPL.[57] They substantially weakened the agency's oversight in determining whether surgical procedures may be safely performed in an ASC. They also removed important patient safety guardrails, which have resulted in higher-risk surgical procedures being covered in ASCs. Indeed, one of the criteria removed in 2026 was intended to prevent a provider who does not have emergency capabilities from conducting surgeries that are emergency or life-threatening in nature.

CMS' proposal is based largely on the agency's concurrent proposal to remove those same 618 procedures from the IPO list. This effectively compounds the clinical and operational concerns raised in the AHA's comments on the IPO list proposal above. In addition, procedures that CMS would newly allow to be performed in an HOPD should not automatically be considered appropriate for the ASC setting, which lacks the same capabilities. Hospitals and HOPDs have access to broader clinical resources, emergency response capabilities, blood products, imaging, laboratory services, intensive care and inpatient admission pathways that may be necessary when complications arise. By contrast, ASCs are designed for a narrower range of outpatient surgical services and may not have the infrastructure necessary to manage unexpected deterioration following complex, invasive or high-risk procedures. **Therefore, the AHA urges CMS to evaluate the removal of procedures from the IPO list and the expansion of services in the ASC CPL as distinct policy decisions — each requiring separate clinical review, evidence, stakeholder engagement and patient-safety analysis. And, with regard to the ASC CPL, we urge the agency to restore the five general exclusion criteria in order to best conduct this clinical review.**

If, nevertheless, CMS finalizes these 2027 proposals, we urge it to work with clinical experts and other stakeholders to make commensurate changes to the ASC Conditions for Coverage (CfC) that account for the fact that these higher-risk services would be covered in the ASC setting, including those specified below. There are complications associated with any major surgery, such as anesthesia-related risks, allergic and other medication reactions, and those related to comorbid medical conditions. ASCs often are not equipped to handle such life-threatening events, and we

[57] The ASC CPL is an official inventory maintained by CMS that specifies which surgical and diagnostic procedures are approved for Medicare facility fee reimbursement when performed in an ASC.

anticipate that if CMS finalizes its proposal, many patients would be sent emergently from ASCs to the nearby hospital ED when such complications arise.

More specifically, in the 2019 Medicare and Medicaid burden reduction final rule, CMS weakened the CfC requirements that required a plan to be in place in the event such emergencies arise.[58] That is, it eliminated the requirement that ASCs have a written transfer agreement with a nearby hospital or ensure that its physicians have admitting privileges at a hospital. Instead, the agency now only requires ASCs to have a procedure for transferring to a hospital and to periodically provide the local hospital with written notice of their operation and patient population served. As a result, if a patient has a medical emergency that cannot be addressed within the capabilities of the ASC, the ASC would call an ambulance and send the patient to the nearest hospital emergency department, without any further responsibility for the beneficiary's condition. Moreover, in 2022, CMS updated Appendix L and interpretive guidelines for state surveyors to eliminate its previous blanket pre-surgery mandate for a medical history and physical assessment for every ASC case and instead made it optional.[59]

Considering CMS' CY 2027 proposal to add many complex and invasive surgical procedures to the ASC CPL, the AHA continues to urge it to restore the CfC requirements regarding written hospital transfer agreements or physician admitting privileges at a hospital and blanket pre-surgery medical histories and physical assessments for every patient. Furthermore, with a broad expansion in the number and kinds of procedures that are proposed for addition to the ASC CPL, including procedures that may have never been furnished in this setting, even greater oversight is necessary to protect Medicare beneficiaries. Absent such safeguards, CMS risks expanding ASC coverage beyond what can be reasonably supported by the clinical resources and emergency response capabilities available in many ASC settings. Specifically, CMS should consider coordinating with clinical experts on enhancements to the anesthesia, emergency equipment and discharge planning standards for the ASC CfCs. We suggest several possible changes that may be worth pursuing for CY 2027, including:

- Making risk evaluations more prescriptive and including an attestation that an individual patient can safely undergo the procedure in an ASC.
- Requiring that an adequate number of nurses be on duty in the ASC.

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[58] Federal Register/Vol. 84, No. 189. (September 2019) "CY 2020 Final Rule. Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care." https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20736.pdf

[59] ASC Focus. (July 2022) "CMS Updates ASC Guidance for Surveyors: Distinct entity, H&P, periodic written notice and anesthesia risk assessment requirements undergo revisions, July 2022." https://archive.ascfocus.org/content2/articles-content/articles/2022/digital-debut/cms-updates-asc-guidance-for-surveyors

- Requiring that staff certified to provide Advanced Cardiac Life Support be present in the ASC in the event of life-threatening emergencies.
- Adding specific CfC requirements that ASCs would need to meet for particular patient conditions or more complex and invasive surgical procedures.

Finally, in addition to the inherent risks associated with more complex services being performed in the ASC setting, 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. This is a particular concern because physician owners of ASCs are not subject to the Stark self-referral regulations and so may have a personal financial interest in performing surgery at an ASC instead of a hospital. To ensure that beneficiaries are aware of this potentially increased financial liability, **the AHA recommends that the ASC CfC patient rights section be revised to require that ASCs inform patients in writing, prior to their procedure, of their copayment obligation. This should include information that, by virtue of the services being performed in an ASC rather than an HOPD, patients may incur higher out-of-pocket costs and the difference in amount.**

PROPOSED ACCREDITING ORGANIZATION ENFORCEMENT OF CERTAIN EMERGENCY MEDICAL TREATMENT AND LABOR ACT REQUIREMENTS

CMS proposes allowing accrediting organizations (AOs) to assess hospitals' compliance with the Emergency Medical Treatment and Labor Act's (EMTALA's) administrative and documentation requirements. The proposed policy would require AOs to verify that hospitals post required signage, maintain records related to patient transfers, keep an on-call list of physicians with medical staff membership or clinical privileges, maintain a central log of individuals presenting to the emergency department and comply with reporting requirements. AOs would be required to incorporate these reviews into their initial accreditation and reaccreditation surveys. CMS and state survey agencies would retain responsibility for enforcing EMTALA's other requirements.

The AHA supports CMS' proposed policy permitting AOs to enforce EMTALA's administrative requirements. Hospitals and health systems take seriously their obligations under EMTALA. With over 80% of U.S. hospitals accredited by an AO, CMS' proposed policy would foster more a more consistent and less operationally disruptive approach to enforcing EMTALA's administrative requirements. These requirements are also procedure and records-based, lending themselves to the type of reviews that are routinely conducted during AO surveys.

In supporting CMS' proposal, the AHA also recommends that CMS make two clarifications. **First, we urge CMS to specify a transition timeline for this policy in the final rule.** To implement this change, CMS would need to communicate the change

to hospitals, state survey agencies and AOs. The AOs would also need time to update their survey procedures and adequately train their survey teams to enforce the new rule. For simplicity and to achieve alignment with updates to AO survey procedures, CMS could consider requiring AOs to implement this policy no later than Dec. 31, 2027.

Second, we urge CMS to work with AOs and OIG to issue clarifying guidance that better enables hospitals to post appropriate signage discouraging threats and acts of violence against healthcare workers. For the past decade, the healthcare field has experienced a sharp increase in workplace violence. A Press Ganey survey found that on average, two nurses are assaulted every hour in the U.S., and a 2024 American College of Emergency Physicians survey found that 9 out of 10 respondents reported having been attacked or threatened in the past year. Workplace violence not only causes physical and psychological injury to healthcare workers, but it also can impede their ability to provide quality patient care. That is why hospitals and health systems have invested in comprehensive workplace violence prevention programs to help keep their patients and care teams safe.

As part of these efforts, hospitals and health systems also want to foster safe, respectful and healing environments for all who are in their facilities. That is why many hospitals find value in placing signage in their facilities that communicates the expectation for respectful behavior and underscores that violence towards staff, patients or visitors is unacceptable and could have consequences. Yet, as the AHA and multiple other healthcare organizations wrote to CMS earlier this year, CMS' existing guidance has created confusion and uncertainty for hospitals. CMS and OIG have asserted that such signage is acceptable if hospitals can demonstrate that they do not deter individuals from remaining in the facility for medical screening examinations and stabilizing treatment. However, the agencies have not explicitly described what constitutes such a deterrent, leaving surveyors to assess compliance only on a case-by-case basis.

The AHA believes that the transition of the enforcement of EMTALA's signage requirements to AOs affords CMS an ideal opportunity to address this issue through written guidance. Such guidance should provide clear guardrails for and illustrative examples of acceptable signage that hospitals could use in their EDs. CMS' efforts here would promote consistency, reduce unnecessary citations, and support and encourage hospitals to maintain safe care environments.

REQUEST FOR INFORMATION: STRENGTHENING THE STANDARDIZATION AND COMPARABILITY OF HOSPITAL PRICE TRANSPARENCY DATA

The AHA appreciates the opportunity to provide comments in response to the request for information on strengthening the standardization and comparability of hospital price transparency data. The AHA and its member hospitals and health systems share CMS' commitment to helping patients and employers access meaningful, accurate and actionable information about the cost of healthcare.

Hospitals and health systems have invested significant resources over the last decade to comply with a growing set of federal and state price transparency requirements, including the Hospital Price Transparency Rule. Unfortunately, the benefit of these efforts for patients, healthcare purchasers and policymakers has barely materialized, primarily due to an ever-changing and highly fragmented policy landscape. The principal barrier to continued meaningful healthcare price transparency is no longer limited access to negotiated rates. The remaining challenge is understanding how negotiated rates, payer policies, benefit design, utilization management rules and claims adjudication processes ultimately translate into patient liability and final payment amounts.

As CMS considers future changes, we urge the agency to first assess the overarching price transparency policy landscape to identify the specific goals it is trying to achieve and areas where greater alignment could lessen confusion and overall costs by reducing unnecessary administrative burden. **Continued one-off changes to hospital machine-readable file requirements, separate and apart from changes to the other price transparency policies, risk increasing administrative costs, generating new inconsistencies, and diverting resources from hospitals' core mission of caring for patients. The changes would not achieve meaningful price transparency for patients, healthcare purchasers or policymakers.**

These policy changes run counter to the Administration's commitment to burden reduction and negatively affect overall healthcare affordability, routinely adding additional costs to the overall healthcare system with limited benefit. To the extent that price transparency policies are intended to achieve greater healthcare affordability, we encourage CMS to explore policies that would reduce, rather than add to, regulatory friction. In addition, CMS could encourage policies that would lead to greater transparency through increased standardization, such as with insurance information or components of the claims adjudication process, which would bring needed clarity to all stakeholders regarding healthcare payments.

Meaningful price transparency also requires consumer education and shared responsibility across stakeholders. Hospitals are working to make financial information easier to find and understand, including through coordinated industry efforts to help patients locate pricing, billing and financial assistance information more easily. But hospitals cannot do this work alone. Health plans possess information critical to patients' understanding of what they may owe and what care they can receive, including patients' coverage details and health plan-specific mid-year policy changes, which are both established and maintained by health plans. We encourage CMS to consider additional opportunities to improve consumer education and navigation of healthcare costs, including through simplified cost-sharing structures.

A. Increasing Transparency of Outlier Provisions and Additional Contract Terms

1. What information is needed for users of the machine-readable files (MRF) to fully understand contract terms related to outlier payments, stop-loss, rate-tiering, carve-outs, and other adjustments that occur across hospital items and services?

If CMS' goal for this policy is to help users better understand likely payment amounts, focusing heavily on contract terms is not the most effective approach. While disclosure of select contract provisions may be useful, CMS should first demonstrate which specific terms materially improve users' ability to understand, compare or predict payment outcomes beyond the newly implemented claims-based allowed amount measures. The financial impact of contract terms such as outlier payments, stop-loss provisions, rate-tiering methodologies, carve-outs and other adjustments generally is reflected through the final adjudicated amount paid on claims. For this reason, claims-based allowed amount data, such as the median, 10th percentile and 90th percentile allowed amounts currently required, can provide a more useful and accurate picture of how these contract terms typically affect payment.

Contract terms themselves are static, conditional pieces of information. They do not, on their own, tell a patient, employer, researcher or policymaker whether the term would apply in a specific case or what effect it would have on the final payment amount. In addition, application of these terms often depends on facts that are not knowable before care is furnished, including the patient's acuity, the services actually provided, the length of stay, utilization management decisions and other claims adjudication factors.

Rather than attempting to require hospitals to encode increasingly detailed contract terms in the MRF, CMS should continue to focus on the claims-based measures that demonstrate how these terms operate in practice. Historic claims data provide an assessment of how the different contract terms and payer policies typically play out in final adjudicated payment amounts. This approach better serves users of the data while avoiding the disclosure of private, competitively sensitive contract information that is unlikely to be meaningful to patients, would increase the size and complexity of the files, and would add additional administrative cost to compliance.

2. How are hospitals currently reporting contract terms for outlier payments, stop-loss, rate-tiering, carve-outs or other adjustments in the MRFs? Are the current formats sufficient for conveying these and other important contract terms? If not, what changes to the current formats, such as separate data elements, would be advised to accommodate the disclosure of such contract terms in a standard manner?

Hospitals report payer-specific negotiated charge information in accordance with CMS requirements and sub-regulatory guidance. However, the current standardized MRF format is not well-suited to conveying the full scope of complex hospital-payer contract terms. Hospital contracts with health plans are often lengthy and highly individualized

and may incorporate multiple payment methodologies, service-specific provisions, payer policies, manuals, coding rules and administrative processes. These arrangements cannot be distilled neatly into a small set of standardized spreadsheet fields without losing critical context or creating misleading impressions.

If the end goal is to better understand likely payment amounts, additional disclosure of private contract terms is unnecessary and potentially counterproductive. Claims-based allowed amount data can show how contractual methodologies are actually applied without requiring hospitals to disclose every underlying contract provision. By contrast, a list of contract terms that could apply would not tell an end user whether the term would apply to a specific claim or how it would interact with other provisions or payer policies.

The AHA also is concerned about the pace and frequency of changes to the MRF requirements. For example, in April 2026 the new standard allowed amount data elements went into effect, and then, two months later in June 2026, CMS released additional guidance addressing how hospitals should encode outlier contracting clauses. Before contemplating additional changes, CMS should assess whether the current requirements and recently released guidance are working as intended. Changes to the MRF structure impose significant operational costs and can reduce usability by forcing hospitals, vendors and end users to repeatedly rebuild their systems and analytic approaches.

3. What additional contracting or payment adjustments affect payer-specific negotiated charges at the item or service level, across items and services, or at the contract level, and should that information be encoded in the current data elements provided? If not, what changes to the current formats would be advised to capture this information in a standard manner?

Payer-specific negotiated charges are not only determined by the written terms of a hospital-health plan contract, but also by health plan-controlled policies, claims edits, manuals, reimbursement rules and administrative interpretations that determine how the health plan adjudicates a claim after the service is furnished, and in some cases unilaterally establish new payment rates or adjust previously negotiated rates.

Hospitals and other providers negotiate in good faith with health plans to establish mutually acceptable payment terms, operational requirements and administrative processes. Yet, provider-payer contracts frequently include broad incorporation provisions requiring providers to comply with health plan policies, procedures, manuals and other administrative guidance. These provisions often do not identify all the incorporated materials, meaningfully limit the scope of future revisions or require the health plan to obtain the provider's agreement before implementing a change that materially affects reimbursement or operations.

Hospitals report that some health plans are relying on these broadly drafted incorporation provisions to impose significant financial and administrative changes that

were neither disclosed nor negotiated when the parties entered into the contract. Health plans may use mid-year policy changes to unilaterally reduce or recapture hospital reimbursement after the parties have negotiated and agreed to payment rates, effectively extracting additional financial concessions outside the established contracting process. These changes can materially alter the economic substance of the parties' agreement while leaving the nominal contractual rate unchanged. As a result, the rate stated in the contract may no longer accurately reflect the amount the health plan will ultimately pay.

CMS cannot achieve accurate and comparable hospital price transparency data by regulating only one party to the transaction. Payers control many of the policies, edits and methodologies that affect the amount ultimately paid. If CMS expects hospital disclosures to account for all policies that can impact a negotiated charge, CMS should require payers to provide hospitals with complete, timely, standardized and contract-specific information about any policy, manual provision, claims edit, severity criterion, reimbursement rule or algorithm that can materially affect payment for a reported item or service.

B. Standardization to Enhance Utility of the MRF

1. Are there challenges in parsing and categorizing the free text fields when analyzing MRFs? If so, what parameters or requirements would facilitate parsing and categorizing free text fields?

To the extent free text fields are difficult to parse or categorize, that challenge reflects the complexity of the underlying information CMS is asking hospitals to report. Complex, individualized contract and payment information does not naturally fit into a standardized spreadsheet. Attempts to force highly variable contract terms into rigid data fields may make the data appear more standardized but also making it less accurate or meaningful.

Before imposing new requirements on free text fields, CMS should more clearly identify the use case for this information and determine whether the information can be obtained through a less burdensome source. For example, if the goal is to understand payment amounts, data elements derived using historic allowed amounts are more useful than additional contract narrative. CMS should avoid requiring hospitals to shoehorn complex contract language into additional standardized data elements absent a clearly defined use case, as doing so would create substantial burden and may generate data that is less accurate because it lacks the context necessary to understand how the terms apply.

2. Should CMS require more structured reporting of payer, plan, product, network, and employer (as applicable) information across hospital MRFs, and if so, which elements should be required? Are there existing identifiers for payers

and plans, to which hospitals have access, that should be incorporated in the MRF?

While additional information on payers, plans, products, networks and employers may be useful, CMS should not require hospitals to publish this information as it is generally maintained by health plans, not providers. Hospitals do not possess complete, authoritative and continuously updated information regarding all plan, network, employer and benefit configurations and therefore would be unable to include it in the MRFs.

This is one reason the AHA has long encouraged CMS to treat Transparency in Coverage data as the primary source for negotiated rate and plan information, as health plans maintain both the historic claims data and the relevant product, network, employer and benefit design information that is most useful to patients. If CMS believes more structured payer and plan information is necessary, the requirement should be placed on health plans or should be developed through a coordinated policy that ensures hospitals have access to accurate, standardized plan identifiers before any reporting obligation takes effect.

3. What additional information should we consider to enhance the utility and comparability of the MRF data?

We respectfully recommend that CMS refrain from making any further changes to the hospital MRF requirements until it undertakes a comprehensive review of the federal price transparency landscape. CMS should assess how the Hospital Price Transparency requirements, Transparency in Coverage requirements, and No Surprises Act good faith estimates and advanced explanation of benefit (AEOB) provisions interact; identify gaps and redundancies; and align requirements so that each policy serves a purpose without creating unnecessary burden on the healthcare system.

For the MRF, the most useful next step is not to add additional information in the files but to move toward greater stability. Hospitals, vendors and end users need time to implement recent changes, gain experience with the data, and determine what is working and what, if any, gaps remain. Continual changes increase cost and reduce usability because every modification requires stakeholders to update files, systems, validation tools, analytic approaches and compliance processes. In addition, CMS should be aware that adding additional data fields will result in larger file sizes, which will further reduce usability of the data. Additional work is needed to ensure that any further changes to the file structure only add information that will enhance utility rather diminish usability.

C. Consumer-Friendly Display Request for Comment

1. Should we revisit the number and types of CMS-specified shoppable services? What are the advantages and disadvantages of increasing or decreasing the

number of shoppable services? Are there specific shoppable services that CMS should include, exclude, or update on the list of 70 CMS-specified items and services?

CMS should not modify the number or list of CMS-specified shoppable services at this time. Hospitals are already required to make available consumer-friendly information for at least 300 shoppable services, and there is no evidence that changing the list would meaningfully improve patient understanding of their out-of-pocket costs.

In addition, uninsured and self-pay patients already receive personalized good faith estimates prior to scheduled care, and once the AEOB requirements are implemented, insured patients will also receive estimates of their out-of-pocket costs for scheduled care. Once fully implemented, these estimates will be patients' best source of information for their expected costs, rather than generic shoppable service lists. Accordingly, CMS should prioritize implementation and refinement of patient-specific tools rather than expanding the list of shoppable services. In addition, we encourage CMS to expeditiously finalize regulations implementing AEOBs, relying on the mock claims framework that would allow providers to transmit good faith estimates using the same electronic format used for claims to ensure the most accurate AEOBs. Once AEOBs are implemented, we urge CMS to reassess the totality of patient-focused price transparency policies to encourage alignment and ensure patient needs are met without unnecessary complexity or duplication.

2. What would be the advantages and/or disadvantages of requiring hospitals to submit a shoppable services file? Alternatively, what would be the advantages and/or disadvantages of removing the deemed compliance for the price estimator tools? Does the current incongruity in how hospitals display shoppable services, with some posting a shoppable services file and others utilizing a price estimator tool, make it more difficult for consumers to actually compare prices for shoppable services across different hospitals? What positive or negative effects would consumers experience if the price estimator tool alone were no longer considered compliant?

The AHA strongly urges CMS to preserve the ability of hospitals to satisfy the consumer-friendly display requirement through price estimator tools. Removing deemed compliance for these tools would be a step backward for patients.

Price estimator tools are more user-friendly than static shoppable services spreadsheets and can provide the information that patients are seeking, such as expected out-of-pocket costs. They can incorporate insurance benefit design, deductible and out-of-pocket maximum status, and patient cost-sharing. Some also include likely ancillary services based on historic claims or predictive analytics. A static shoppable services file cannot replicate this functionality or usability.

Requiring hospitals to submit a shoppable services file instead of maintaining price estimator tools would create substantial administrative burden with little demonstrated patient benefit. It also could introduce new opportunities for confusion and error. Patients would be left to navigate complex spreadsheets and determine which line item corresponds to the care their clinician ordered, and then separately would need to contact their health plan to understand and apply their benefit design and cost-sharing.

A recent focus group on price transparency confirmed patients' strong preference for price estimator tools over a static, consumer-friendly spreadsheet. During the focus group, participants noted that the shoppable services files are confusing and difficult to navigate, with all participants favoring the price estimator tools over the shoppable service spreadsheet.

If CMS removes deemed compliance for price estimator tools, consumers will likely experience more friction, less personalization and less accurate estimates. Such a policy would undermine the progress hospitals have made in developing patient-friendly tools and would divert resources away from the transparency solutions patients find most useful.

3. For hospitals that satisfy the consumer-friendly display requirements through a price estimator tool, what mechanisms could be used to make the underlying data available in a separate file?

It would be extremely difficult, and in some cases impossible, to create a static flat file containing the underlying data used by a price estimator tool. These tools often rely on dynamic information that changes regularly, including updated charge information, payer contract data, benefit information, deductible status, prior utilization and historical claims patterns. A static file would become outdated quickly and could be misleading.

In addition, price estimator tools may draw from multiple data sources, including information supplied by health plans. Hospitals may not possess or control all the data used to generate the estimate, particularly information about a patient's coverage, cost-sharing obligations, or accumulated deductible and out-of-pocket spending.

CMS should not require hospitals to create a separate file that attempts to replicate the data underlying a price estimator tool. Such a file would be burdensome to create, difficult to maintain and less useful to patients than the tool itself.

4. Are there circumstances in which the standard charges in a hospital's shoppable services file would not match the information for the same items and services listed in the hospital's MRF? Why would a hospital be able to provide a discounted cash price in its price estimator tool but not in its MRF?

Yes, there are circumstances in which information displayed through a price estimator tool or shoppable services display may not match the hospital MRF. These differences

can arise because the tools are designed for different purposes and operate at different levels of granularity.

The MRF often reports pricing at a detailed component level, such as a specific chargemaster item, CPT/HCPCS code, DRG or fee schedule rate. A price estimator tool, by contrast, may generate an estimate for an anticipated episode of care or bundled encounter. For complex or bundled services, the tool may use historical claims data to estimate the typical resources furnished during a patient encounter, including ancillary services that may not be obvious to the patient in advance.

Price estimator tools also may be updated more frequently than the MRF and may incorporate additional data. They may reflect dynamic claims experience, updated payer information, patient-specific benefit details or changes in service patterns. Differences related to discounted cash prices also can occur where the tool is able to account for operational factors or payment arrangements that are not easily represented in the MRF. These differences do not mean the tool is less accurate or that the MRF data are incorrect. Rather, these differences reflect that the price estimator tools are designed to provide a patient-friendly estimate, while the MRFs are designed as a comprehensive public data file.

5, 6 & 7. Which data elements are important for consumers to make comparisons between hospitals? Would a standard shoppable services file template make the information more comparable? How could a shoppable services file indicate the ancillary services that are included in or excluded from the price? How should hospitals present ancillary items, implants, and bundled services so consumers better understand total expected costs? What approaches most effectively distinguish included versus excluded services? What additional information should we consider to enhance the comparability of the consumer-friendly display data between hospitals?

CMS should not assume that a shoppable services file would make cross-hospital comparison easy or meaningful. Hospital-based tools, whether presented as a flat file or a dynamic online price estimator, are designed primarily to help patients understand expected costs at a specific hospital. Cross-provider comparison is better suited to health plans' self-service tools because plans have information on all in-network providers, as well as the patient's benefit information and out-of-network coverage. CMS should focus on ensuring that health plan Transparency in Coverage self-service tools function effectively for comparison purposes, while allowing hospital tools to remain focused on providing accurate, patient-specific estimates for care at a particular hospital.

More broadly, CMS should avoid creating duplicate or conflicting requirements across hospital and health plan tools. The goal should be a coordinated ecosystem in which each policy plays a clear role: Hospital price estimator tools provide facility-specific estimates; health plan tools support cross-provider comparison; and uninsured/self-pay

good faith estimates and AEOBs provide patient-specific estimates for scheduled care. This coordinated approach would better advance meaningful price transparency than additional changes focused solely on the hospital requirements.

In terms of ancillary services, price estimator tools are better positioned than static shoppable service files to explain likely ancillary services and provide an estimate that reflects how care is typically delivered. Some hospital price estimator tools also include plain-language explanations of what is typically included, what may be excluded, why the final cost may vary and the contact information for financial counselors should a patient have additional questions.

Static files are less effective for this purpose. A spreadsheet may list ancillary items or excluded services, but it is unlikely to do so in a way that is intuitive or actionable for most patients. For example, ancillary services and implants may vary based on clinical circumstances that are not known until care is delivered and it would be hard to clearly denote what is most likely versus the universe of possible services in a flat file.

CONSIDERATION OF POTENTIAL APPROACHES FOR SEPARATE INPATIENT PPS PAYMENT FOR DOMESTIC PROCUREMENT OF PERSONAL PROTECTIVE EQUIPMENT AND ESSENTIAL MEDICINES

Earlier this year, CMS sought public comment on potential options the agency could consider to help foster a more resilient supply chain for American-made personal protective equipment (PPE) and essential medicines to secure our nation's health and safety and to reflect the additional resource costs incurred when procuring these domestically manufactured items. The agency is now seeking further public input. Specifically, it is seeking comments on potential policy approaches for a payment adjustment, a methodology to calculate the price differential between domestic and non-domestic PPE and essential medicines, information sources of those price differentials, a definition of domestic essential medicine and PPE, and a process for verifying that a given essential medicine or PPE is "domestic."

The AHA appreciates CMS' recognition that a more reliable and resilient drug supply chain is needed so that hospitals can better care for their patients and communities. We thank CMS for soliciting additional feedback on this separate payment; our additional recommendations follow.

Potential Eligible Domestic PPE Products and Cost Differentials

CMS is considering expanding the PPE products eligible for the separate inpatient PPS payment adjustment to include all domestic National Institute for Occupational Safety and Health-approved respirators that demonstrate compliance with the American Society for Testing and Materials (ASTM) Respirator Fit Capability Standard, domestic medical gloves in compliance with FDA requirements and conforming to ASTM

standards, and domestic gowns in compliance with FDA requirements and conforming to Association for the Advancement of Medical Instrumentation standards. The agency is not considering including other PPE products such as face shields, protective eyewear, surgical masks, and head and foot coverings at this time.

The AHA supports CMS' intent to expand eligible respirators to those described above and continues to encourage the agency to expand this program to include a similar payment adjustment for domestically made nitrile gloves, gowns, syringes, needles and other commonly used PPE. These are all essential medical supplies largely manufactured, in part or wholly, in other nations and have experienced serious shortages in recent years. Extending the policy to these other supplies would make the program more attractive to manufacturers considering expanding their domestic footprint. In addition, including additional domestically made essential medical supplies in the program would improve hospital participation in the program as this would be an opportunity for them to offset increased costs for additional high-volume, domestically made supplies. Finally, increased demand for these domestically made essential medical supplies would likely strengthen the supply chain, leading to a more consistent flow of products in the event of an emergency.

Additionally, the agency is considering adding to the definition of the term "domestic" for PPE products to also mean those that comport with the Make PPE in America Act, which identifies American-made PPE as "domestically-made from domestic materials and components that are grown, reprocessed, reused, or produced in the United States."[60] **We appreciate and support that the agency is considering expanding the definition of eligible products to also include those that would qualify using the Make PPE in America Act.** As we stated above, expanding the eligible list of products would improve hospital participation and is more likely to strengthen the supply chain.

Potential Eligible Domestic Essential Medicines and Cost Differentials

CMS previously finalized a program that provided separate payment under the inpatient PPS to small, independent hospitals for the estimated additional resource costs of voluntarily establishing and maintaining access to a six-month buffer stock of one or more of the Advanced Regenerative Manufacturing Institute (ARMI) List's essential medicines. The essential medicines included in the ARMI List were those that were most critically needed for typical acute patient care. In this context, acute patient care was defined as: rescue use or lifesaving use or both (that is, intensive care units, cardiac/coronary care units and EDs), stabilizing patients in hospital continued care to enable discharge, and urgent or emergency surgery. However, the previously finalized program did not require that these essential medicines be domestically produced.

[60] Make PPE in America Act, (section 70953 of Pub. L. 117–58).

In this RFI, CMS states that it is considering a new potential payment policy that would include separate payment for certain FDA-approved medicines from the ARMI List only if they have existing United States finished dosage form production and do not contain active pharmaceutical ingredients from countries listed on the "foreign adversaries" list. **The AHA supports the development of such a policy.** However, we urge CMS to consider including additional critical medicines, such as drug products manufactured in Organization for Economic Co-operation and Development countries, to this program such that it fulfills the intent of building a more resilient and reliable drug supply chain more meaningfully.

Public File of Potential Eligible Domestic PPE and Potential Eligible Domestic Essential Medicines

The AHA has previously stated that hospitals have limited to no information from manufacturers regarding their manufacturing and supply chain process. Thus, the burden of identifying which PPE and essential medicines are manufactured domestically would have squarely fallen on hospitals. As such, we have urged CMS to develop a publicly available list of fully domestically produced products eligible for the payment adjustment. To that end, CMS is now considering that manufacturers of potentially eligible domestic PPE and essential medicines would voluntarily submit annual attestations to HHS that their products meet CMS' domestic definitions. HHS would compile this information and create an annual file of eligible domestic products and domestic cost differential estimates that would include the National Drug Codes (NDCs) or Unique Device Identifier for each product. The AHA fully supports the creation of such a public file as it would provide hospitals with a simple, reliable reference for identifying eligible domestic products and the estimated domestic cost differentials. **We thank CMS for proposing to create this less burdensome way for hospitals to identify eligible products.**

Inpatient PPS Payment Adjustments for Domestically Purchased PPE and Essential Medicines

In this rule, CMS is considering two approaches for the inpatient PPS payment adjustment for domestically purchased PPE and essential medicines. For essential medicines, under approach 1, the claims processing system would use the domestic cost differentials to automatically calculate and make the payment based on the domestic NDCs and units of those NDCs. This approach would require that hospitals report NDCs on the claim. Under approach 2 for essential medicines, a hospital would voluntarily calculate the payment across all its inpatient PPS stays during its cost reporting period and report that aggregated information on its cost report instead of billing individually on its inpatient PPS claims. The payment is the same under both approaches, but the hospital would not need to submit the NDCs on the claim under approach 2.

We have concerns about both approaches. Under approach 1, we are concerned about the complexity and burden that would be imposed on hospitals if they had to report NDCs on each inpatient claim. Such a requirement would create substantial administrative burdens. This is because inpatient billing relies on bundled ICD-10-PCS codes rather than itemized drug tracking, meaning the policy would force expensive overhauls of electronic health records, billing software and internal revenue workflows. Moreover, there are multiple NDCs which usually apply to one drug product. This is because an NDC identifies not just the drug itself, but also the specific package size, type, and manufacturer or distributor. Approach 2 is also not ideal as it would create massive retroactive data-matching and accounting hurdles. These concerns raise feasibility, system and administrative burden issues that must be addressed if CMS were to pursue this approach. **We urge CMS to consider and pursue a reporting process that is least administratively burdensome to hospitals and streamlined in its approach for both inpatient and potential future outpatient PPS payments.**

Maximum Annual Amount of Aggregate Payments

CMS states that it may be prudent to establish an appropriate maximum annual amount of separate payments that would be available across all inpatient PPS hospitals. To implement such an approach, the agency states that it could prospectively allocate shares of this aggregate amount to individual hospitals before the start of the fiscal year. If the actual separate payment to a hospital for the fiscal year exceeds its allocated maximum amount, the excess amount would be reconciled at cost report settlement. **We disagree with this reasoning and potential policy. It does not make sense to essentially retroactively impose caps that put hospitals back at financial risk for the very actions CMS is trying to incentivize.** Doing so would not help achieve the agency's goal of incentivizing hospitals, manufacturers and the entire supply chain to invest in domestically made PPE and essential medicines.

Furthermore, we urge that the agency clarify in any future proposals that inpatient PPS PPE-related incentive payments would not be made in a budget-neutral manner. In addition, we urge it to seek Congressional authority to make outpatient PPS payments non-budget-neutral. Redistributing payments from an already underfunded system will not be of benefit to providers or to patients.