Illinois Health and Hospital Association

September 15, 2025

Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems (CMS-1834-P)

Dear Administrator Oz:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year 2026 (CY26) Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system proposed rule. **We are deeply concerned about several policies outlined in this proposed rule.** Coupled with the significant Medicaid cuts recently enacted by Congress in H.R. 1, the proposals put forth by the Centers for Medicare & Medicaid Services (CMS) for the OPPS create financial and operational burdens that threaten to discontinue service lines, or worse, force hospitals across the state of Illinois to close.

We continue to be disappointed with CMS' consistent underfunding of the OPPS. CMS' proposed rate update of 2.4% does not even cover inflation,[1] let alone the increased costs hospitals face. In the Midwest, hospitals are experiencing a 6%[2] increase in costs year-to-date in 2025 (compared to 2024). More than half of Illinois hospitals operate on slim to negative margins, a trend that has persisted over the last decade, proving that all payers, including Medicare, are consistently underpaying hospitals.

CMS' longstanding reliance on IHS Global Inc.'s forecast data to calculate market basket updates has exacerbated this already strained system, undervaluing the true increase in costs to America's hospitals year after year. And while CMS updates its final methodology each year using the most recent data available, those updates never cover the cost of care or even keep up with inflation. We have expressed in the past that using a time-lagged estimate to update the OPPS market basket is no longer sufficient. Simply put, the healthcare market is too volatile, and policy is shifting too quickly, for historical data to accurately set present or future reimbursement.

Further, CMS has also proposed an expedited recoupment of 340B-related overpayments which would result in an even lower rate update. Should CMS continue

[1] https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/inflation/Monthly%20Inflation%20Update%20(PDF).pdf
[2] https://www.kaufmanhall.com/sites/default/files/2025-08/KH-NHFR-Report_June-2025-Metrics.pdf

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to stand firm in its reliance on IHS Global Inc. data to update the OPPS, it should do everything under its authority to preserve or improve payments to hospitals via other policy making. Instead, this proposed rule includes numerous proposals, including the expedited 340B recoupment, that would further drive reimbursement down.

We strongly urge CMS to reassess the data and methodology used for the annual market basket update and formulate a process that better reflects the fiscal reality faced by America's hospitals. Further, CMS should reexamine portions of this proposed rule and finalize policies and payment updates that better reflect the economic and logistical realities hospitals currently face.

Implementing a PFS-Equivalent Payment Rate for Drug Administration Services in Excepted Off-Campus Hospital Outpatient Departments

We oppose CMS' proposal to reduce the payment for drug administration services furnished in excepted off-campus hospital outpatient departments to the "PFS-equivalent" rate of 40% of the OPPS rate. We also oppose an expansion of such site-neutral cuts to other services furnished in hospital outpatient departments. **We urge the agency to withdraw these proposals from consideration.**

CMS lacks statutory authority to reduce payments to excepted hospital outpatient departments to the level of nonexcepted hospital outpatient departments, particularly in a nonbudget-neutral manner. The proposed rule states that "section 1833(t)(2)(F) of the [Social Security] Act provides authority to implement this policy," and that the D.C. Circuit's decision in *American Hospital Association v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), supports its interpretation. But legal developments since that decision cast significant doubt on its continued viability and, more importantly, undermine the agency's reliance on Section 1833(t)(2)(F).

Specifically, the proposed rule fails to address three critical legal deficiencies in relying on *American Hospital Association v. Azar*. These are: (1) with the Supreme Court's overturning of the *Chevron* framework, the agency's interpretation of Section 1833(t)(2)(F) is not entitled to deference and does not provide the U.S. Dept. of Health and Human Services (HHS) with statutory authority to implement this policy; (2) more recent Supreme Court decisions like *Biden v. Nebraska* and *West Virginia v. EPA* have strongly emphasized that agencies cannot fundamentally rewrite statutes, but HHS is doing precisely that in using Section 1833(t)(2)(F) to completely evade the OPPS system; and (3) the proposed rule does not address Section 603 of the Bipartisan Budget Act of 2015, which does not cover hospital outpatient departments established before November 2015.

CMS also fails to consider other explanations for the increase in drug administration. We disagree that higher payments for these services are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." This assertion ignores many factors that have led physicians to abandon private practice and seek employment in hospital outpatient departments, including inadequate

payments from both Medicare and private payers, as well as excessive administrative burdens.[3,4]

Additionally, CMS' proposal equates care provided in hospital clinics with less complex care provided at independent physician offices and other free-standing sites. However, such care is not equivalent, and current OPPS payment rates take into account significant differences. For example, hospitals are required to take many additional measures to make certain that medications are prepared and administered safely while also providing important care coordination services for their patients. Hospitals must take steps to ensure that a licensed pharmacist supervises drug preparation, rooms are cleaned with positive air pressure to prevent microbial contamination and employees are protected from exposure to hazardous drugs. In addition, hospitals must remain in compliance with important safety standards such as those required by the Food and Drug Administration, U.S. Pharmacopeia, and The Joint Commission.[5] None of these requirements are in place for drug administration in independent physician offices.

Finally, the proposal does not account for the fact that hospital outpatient departments serve a sicker, more clinically complex and more economically vulnerable Medicare population.[6,7] Simply put, independent physician offices and hospital outpatient departments are reimbursed at different rates because the cost of providing care in each location is vastly different. At the same time, any increases in hospital outpatient department drug administration rates are driven by myriad factors, including but not limited to the reality that physicians are increasingly seeking sustainable employment arrangements through hospitals due to Medicare under reimbursing them via independent practice arrangements. Lowering OPPS reimbursement to "PFS-equivalent" rates will only intensify these issues.

Proposed 340B-Related Conversion Factor Decrease

The Supreme Court unanimously found that CMS inappropriately implemented a 340B reimbursement policy from CY18 through CY22, requiring the agency to remedy their unlawful decrease in 340B reimbursement for covered outpatient drugs. In response, CMS finalized a remedy that would repay 340B hospitals in a one-time lump sum, totaling $10.6 billion, as well as recoup $7.8 billion from all OPPS hospitals for the increased OPPS payments received for non-drug services from CY18 through CY22. The goal of this remedy was to restore all providers to the same position as if the policy had never been in place. This finalized recoupment strategy reduces the OPPS conversion factor by 0.5% annually beginning in CY26 until the full $7.8 billion is recouped.

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[3] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf

[4] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care

[5] https://www.aha.org/system/files/media/file/2023/11/aha-ashp-letter-opposing-site-neutral-legislation-11-14-2023.pdf

[6] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

[7] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

CMS is now proposing an expedited recoupment timeline by adjusting the reduction to the OPPS conversion factor from 0.5% to 2%. CMS stated this will minimize the impact of potential changes in non-drug services over time and ensure a more equitable impact on all hospitals, stating "the longer it takes for us to fully recover the $7.8 billion, the less likely that the relative burden on hospitals from the adjustments will match the relevant benefits those hospitals previously received." CMS also stated it is considering an even more expedited timeline, reducing the OPPS conversion factor by 5% resulting in full recoupment of the $7.8 billion in approximately three years.

IHA does not support either of these proposals and strongly requests CMS to withdraw both policy suggestions before finalizing the CY 2026 OPPS rule. Simply put, we maintain our past comments that CMS does not have the authority to recoup these payments.

As we have stated previously, a plain reading of sections 1833(t)(9)(B) and 1833(t)(14)(H) of the Social Security Act does not require (nor permit) HHS to make budget neutrality adjustments for past payments. The Social Security Act clearly states budget neutrality is made prospectively. Budget neutrality is required for future payments and is meant to adjust the groups, relative payment rates, and wage indices in the OPPS for the upcoming year, taking into account changes in services, changes in technology, new cost data, etc. Budget neutrality is not required for payments that have already been made.

Despite this, CMS finalized a recoupment policy via CMS-1793-F. OPPS hospitals took that finalized rule at face value, utilizing the 0.5% decrease to the OPPS conversion rate when completing budget forecasts for their facilities. Increasing this rate change now is inappropriate and would be devastating for OPPS hospitals that are already struggling with small to negative operating margins. CMS should instead maintain the recoupment policy finalized in CMS-1793-F, respecting the notice-and-comment rulemaking process as well as the stakeholders that participated in it.

Revising Requirements for Hospitals under CMS Hospital Price Transparency Regulations

Illinois hospitals have long been committed to providing transparency around prices and patient obligations, sharing the Administration's goal of giving patients clearer, more actionable cost information. That is why we also support the Transparency in Coverage rules that require health plans to assist patients with their cost obligations under certain plans, complimenting the information hospitals make available on their websites. We support CMS efforts focused on policies that directly help patients in their decision making. We ask CMS to forgo policies that increase hospital administrative burden without improving patients' understanding of healthcare costs. With that background, we offer the following concerns about CMS' proposed changes to hospital price transparency requirements.

<u>Attestation Concerns</u>

We find the proposed update to the machine-readable file attestation language problematic. The proposed change requiring hospitals to affirm they have provided "all necessary information" for the public to derive service prices fails to account for the reality of hospital

billing which depends on the behavior of payers and plan-specific information that the hospital would not have. **Therefore, we urge CMS to retain the current "good faith effort" attestation, which reflects what hospitals can realistically provide.**

In addition, CMS proposes to require CEOs or other senior executives to sign the attestation. Hospital CEOs are not in the best position to attest to the accuracy of the machine-readable files, as they have hired individuals specifically trained in charges and reimbursement to compile these data. CMS should instead trust the good faith of hospital employees who are far closer to the required information and can verify its accuracy far more easily than someone higher on the organizational chart with broader responsibility. **Therefore, we encourage the agency not to finalize this proposal.**

Allowed Amount Data Elements

CMS also proposed requiring hospitals to publish median, 10th percentile and 90th percentile allowed amounts, plus a count of the claims used for the calculations. **This increase in regulatory burden presents concerns around patient privacy, particularly for low volume services.** Similarly, we have concerns about calculating medians and percentiles for low volume services, as the outcome will likely be skewed.

Additionally, we strongly request that CMS allow hospitals at least one year to adopt the new data elements proposed in this rule. Many hospitals struggle to keep up with the annual changes under the hospital price transparency regulations, requiring them to contract with external firms to maintain compliance. Every time CMS makes changes to the program, the cost of compliance increases. At a time when hospital resources are stretched thin, we are concerned about the additional burden the new requirements would place on hospital staff, especially given the short timeline for implementation.

Collection of Market-Based Payment Rates Information by MS-DRG on the Medicare Cost Report

We are concerned about the proposed collection of market-based payment rate data on the Medicare cost report for cost reporting periods ending on or after Jan. 1, 2026. Under this policy, hospitals would use the payer-specific negotiated charges from their most recent machine-readable file published prior to the submission of their cost report to report the median payer-specific negotiated charge that they negotiated with contracted Medicare Advantage organizations. CMS would then use the submitted information to set Inpatient PPS relative weights beginning in fiscal year 2029.

This proposal contains serious policy deficiencies, and we strongly urge its withdrawal. Specifically, this proposal would impose a significant new regulatory burden on hospitals. Regulatory burden requires hospitals to deviate employees and resources away from care delivery toward business operations, impacting access for the communities they serve.

The policy also ignores critical issues associated with the use of Medicare Advantage negotiated rates to set Medicare fee-for-service MS-DRG relative weights. For example, Illinois' rural

hospitals often operate in markets that are controlled by one or two Medicare Advantage payers and report difficulties negotiating adequate reimbursement rates. Using these rates to set Inpatient PPS relative weights would further aggravate an already precarious financial reality that challenges the ability of rural hospitals to remain open and providing care to their communities.

Finally, the impacts of this proposed policy have not and cannot be analyzed because the underlying data are not currently maintained in the format CMS would require. **Using Medicare Advantage data to overhaul the Inpatient PPS relative weights without first understanding the potential impact to care access and delivery is irresponsible, and we are very concerned about the substantial negative impacts for Illinois hospitals and the communities they serve.**

Elimination of the Inpatient-Only (IPO) List

IHA strongly opposes CMS' proposal to eliminate the IPO list. The IPO list was created to protect beneficiaries, and many of the services on the IPO list are complicated and invasive surgeries. These services may involve multiple days in the hospital, special protections against infections, and significant rehabilitation and recovery periods, requiring the care and coordinated services of the inpatient setting of a hospital.

While removing a service from the IPO list does not, on the surface, prevent the service from being offered in the inpatient setting, we are concerned that there are unintended consequences that will arise should CMS finalize this proposal. Payers, including government payers, Medicare Advantage plans, and commercial insurers, are consistently looking for opportunities to provide care at lower cost. While the goal is laudable, it often comes at the expense of the patient via additional administrative hoops providers need to jump through. Utilization management practices have gotten out of hand, jeopardizing the ability of physicians to use their specialized training and knowledge to make the best decision with their patient about that patient's care.

Simply put, dismantling the IPO list will drive more providers toward utilization management processes that impede healthcare access and delay medically necessary care. There is no evidence presented by the Administration that patients are kept in the hospital longer than necessary following a procedure listed on the IPO list. Furthermore, the current process for removing a procedure from the IPO list considers important factors like average length of stay, peer-reviewed evidence, and patient factors, such as comorbidities and age. Payers often neglect such considerations and considering the growth in Medicare Advantage plans that operate largely outside the purview of CMS oversight, phasing out the IPO list will not only impact provider decision making, but will hurt Medicare beneficiaries as they try to access critical healthcare services.

Instead of eliminating the IPO list, IHA recommends that CMS continue its standard process in considering the appropriate removal of procedures from the IPO list. This process is designed to consider new technologies, advancement in medical knowledge, and improvements in care

delivery while maintaining physician autonomy and preserving the physician-patient relationship.

Supervision of Certain Rehabilitation Services

We support making permanent the definition of direct supervision for cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) and pulmonary rehabilitation (PR) services and diagnostic services in hospital outpatient departments to include virtual direct supervision. Illinois hospitals, particularly those located in rural areas or experiencing cardiac rehabilitation specialist shortages, have appreciated this flexibility as it improves access to care for their patients. Permanently allowing direct supervision of CR, ICR, and PR services and diagnostic services via two-way, audio/visual communication technology (excluding audio only) will provide stability to hospitals as they consider staffing opportunities and how to best facilitate the care their communities need. **We support CMS in finalizing the definition of direct supervision for CR, ICR and PR services and diagnostic services as proposed.**

Quality Reporting Programs

Removal of Social Drivers of Health Measures

IHA acknowledges CMS's decision to remove the social drivers of health (SDOH) screening measures from the Hospital Outpatient Quality Reporting Program. While our member hospitals appreciate the reduction in administrative burden associated with these reporting requirements, we maintain that screening for and addressing SDOH remains essential to patient care and directly supports CMS's goal of "Making America Healthy Again." Social factors such as food insecurity, housing instability, and transportation barriers significantly impact patient outcomes, treatment adherence, and the ability to maintain wellness between visits. Our members have made substantial investments in SDOH screening infrastructure, staff training, and community partnerships, and we appreciate the opportunity to operationalize this work in a way that is more appropriate than the one-size-fits-all approach previously implemented by CMS.

By maintaining robust SDOH screening and intervention programs, hospitals directly advance the wellness and nutrition goals central to Making America Healthy Again. Identifying and addressing food insecurity, for example, enables more effective nutrition counseling and ensures patients have access to healthy foods necessary to improve and maintain health. Our hospitals and their outpatient care sites remain committed to these efforts and look forward to collaborating with CMS on policies that support comprehensive, whole-person care while reducing unnecessary administrative burden.

Proposed Modifications to the Overall Star Rating Methodology, Emphasizing Safety of Care

IHA appreciates the work CMS has done to improve the Overall Star Rating Methodology over the last several years. The methodological updates CMS proposes to emphasize safety measures within the Overall Star Ratings make sense in that a system meant to inform patients

about the quality of care they will receive at a facility should reflect the safety of services provided at that facility.

However, the Overall Star Ratings methodology remains flawed, particularly in that it is biased against hospitals, often Safety Net Hospitals and Critical Access Hospitals, that do not have the volume of data needed to impact their star ratings score. Indeed, recently an Illinois Safety Net Hospital saw their Overall Star Ratings drop from 3 stars to 1 star because they did not have the required volume to report a handful of measures, despite significant improvement with many of their healthcare associated infection and patient experience measures.

IHA suggests CMS address flaws in the underlying methodology of the Overall Star Ratings rather than attempting to make ornamental changes at the periphery. Patients deserve accurate information, and hospitals deserve to be held accountable for the work they do, not punished for treating a smaller number of patients.

Administrator Oz, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association