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September 15, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1834-P
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-1834-P; Medicare Program; Hospital Outpatient Prospective Payment System for Calendar Year 2026; Proposed Rule

Dear Administrator Oz:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, welcomes the opportunity to comment on the Medicare Outpatient Prospective Payment System proposed rule for calendar year 2026. Our comments are arranged by topic area below.

Inadequate payment update

For CY 2026, CMS proposes a 3.2% market basket update. This update is inadequate and needs to be increased to reflect cost increases facing acute care hospitals.

According to HANYS and our allied associations' 2024 fiscal survey report, from 2019 to 2024, New York hospitals reported that drug costs rose by 83% and supplies and labor costs were up 36% — costs that have all risen faster than inflation since 2019 and that are not recognized in the Medicare market basket updates.

In CYs 2022, 2023 and 2024, CMS provided market basket updates of 2.7%, 4.1% and 3.3%, respectively. More recent data show the deficiency in the market basket for these years, with the actual updates estimated to be 5.7%, 4.8% and 3.6%, respectively.[1]

The market basket's ongoing shortcomings perpetuate underpayments to acute care hospitals since future payment adjustments continue to be based on these updates.

While we appreciate that CMS will update the market basket in the final rule based on more recent data, the recent past has proven that this year's update will be inadequate compared to the actual costs hospitals are absorbing. When CMS underestimates the market basket update under the Skilled Nursing Facility PPS, the agency makes a forecast error adjustment. **In the context of the SNF approach and the recent disparity between estimated and actual market basket values, we**

[1] CMS. Market Basket Data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

urge CMS to make a one-time 4.0 percentage point increase to the OPPS market basket in CY 2026, in addition to a traditional market basket update, to account for the underpayments that occurred in CYs 2022 through 2024. This would provide hospitals in New York and across the country some stability to maintain and improve access to patient care.

CMS also proposes to offset the 3.2% market basket update by a productivity cut of 0.8 percentage points. CMS updates the productivity adjustment annually based on the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity. This measure assumes that the hospital sector can achieve the same rate of productivity gains as the private non-farm business sector. However, in an economy with great uncertainty due to rising drug, supply and labor costs, this assumption departs from economic reality.

While we understand that the productivity adjustment is required under the *Affordable Care Act*, **we ask CMS to consider using its "special exceptions and adjustments" authority to eliminate the productivity cut for CY 2026 given the financial challenges hospitals continue to face as they try to maintain access to services**.

Additionally, CMS is also proposing to expedite the 340B remedy rule budget neutrality payment cut by increasing the finalized 0.5% cut to 2% beginning in CY 2026. If all updates are adopted as proposed, most providers will experience less than a 1.0% increase over the CY 2025 outpatient payment rates. This is unsustainable.

Low wage index policy

As stated in our previous comments, **HANYS supports the discontinuation of the low wage index policy** that raises the wage index of the lowest quartile wage index hospitals by half the difference between the 25th percentile wage index value and the hospital's individual wage index because it does not appropriately address the fundamental problems with the current wage index system.

However, HANYS opposes using a downward adjustment to the conversion factor to implement the transitional period for those disadvantaged by the discontinuation of the policy in a budget-neutral manner. Reducing the conversion factor for all hospitals to continue the transitional period intensifies Medicare underpayments.

Site-neutral payment cuts for drug administration

Currently, CMS pays all off-campus, provider-based department basic clinic visits identified by service code G0463 at a reduced site-neutral rate, regardless of excepted or non-excepted status as defined by Section 603 of the *Bipartisan Budget Act of 2015*. In this rule, CMS proposes to expand the site-neutral payment cuts to include all 61 HCPCS codes assigned to APCs 5691 through 5694 for drug administration for "excepted" off-campus PBDs. **HANYS aligns with the AHA and continues to strongly oppose any payment rate cuts for excepted off-campus PBD sites, including an expansion to include drug administration.**

While Section 603 clearly protects off-campus PBDs billing Medicare for outpatient services on or before Nov. 2, 2015, (referred to as "excepted sites") from site-neutral payment reductions, CMS cites its authority under section 1833(t)(2)(F) of the Act to "develop a method for controlling unnecessary increases in the volume of covered outpatient department services." The D.C. Circuit's decision in *American Hospital Association v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), supports its interpretation.

However, HANYS aligns its view with the AHA. Recent legal developments since that decision cast serious doubt on the viability of this approach and undermine the agency's reliance on Section 1833(t)(2)(F). Specifically, the proposed rule fails to deal with three critical legal deficiencies in relying on *American Hospital Association v. Azar*. These are:

- the Supreme Court's recent decision to overturn the Chevron framework eliminates judicial deference to agency interpretations of ambiguous statutes. As a result, HHS' interpretation of Section 1833(t)(2)(F) must be independently justified and is not entitled to deference, weakening its legal foundation for the proposed policy;
- in more recent decisions like *Biden v. Nebraska* and *West Virginia v. EPA*, the Supreme Court emphasized that agencies cannot fundamentally rewrite statutes. HHS' use of Section 1833(t)(2)(F) to circumvent the OPPS constitutes a significant statutory rewrite, which is impermissible under this doctrine; and
- the proposed rule fails to address Section 603 of the *BBA of 2015*, which limits OPPS payments to off-campus hospital outpatient departments established after Nov. 2, 2015. HOPDs established before that date are excepted and should not be subject to the same payment restrictions. The rule's silence on this issue creates statutory conflict and undermines its legal coherence.

Given these substantial legal issues, HHS should reconsider its reliance on Section 1833(t)(2)(F) and the precedent set in *American Hospital Association v. Azar*. The proposed rule risks exceeding statutory authority and contradicts recent Supreme Court guidance. A revised approach that aligns with current legal standards and statutory limitations is strongly recommended.

In addition, HANYS also agrees with the AHA that CMS fails to consider alternative explanations for the rise in drug administration services. We disagree with the claim that higher payments are driving hospitals to acquire independent physician practices and causing an "unnecessary increase in the volume of services." This perspective overlooks numerous factors contributing to the shift away from private practice, including inadequate reimbursement from both Medicare and commercial payers, as well as the growing administrative burdens placed on physicians. [2]

Furthermore, CMS' proposal incorrectly equates the care delivered in hospital outpatient clinics with the less complex services provided in independent physician offices and other free-standing settings. This comparison is flawed, as the nature and complexity of care in hospital settings are fundamentally different and current OPPS payment rates appropriately reflect those distinctions. For example, hospitals must adhere to rigorous safety protocols to ensure medications are prepared and administered safely, including oversight by licensed pharmacists, use of positive air pressure rooms to prevent contamination and protections for staff handling hazardous drugs. Additionally, hospitals are required to comply with stringent standards set by entities such as the Food and Drug Administration, U.S. Pharmacopeia and The Joint Commission, which do not apply to independent physician offices.

Lastly, the proposed rule does not address the fact that hospital outpatient departments treat sicker, more clinically complex and more economically vulnerable Medicare populations than independent physician offices. According to a new study released by the AHA,[3,4] Medicare beneficiaries primarily treated in HOPDs as compared to independent physician offices are more likely to:

- be under 65 and disabled;

[2] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf
[3] "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
[4] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024," KNG Health Consulting, LLC, September 2025

- be dual-eligible;
- come from communities with lower income and reside in rural counties; and
- have more severe chronic conditions and higher prior utilization of hospitals and emergency departments.

For the reasons described above, HANYS strongly urges CMS to withdraw its proposal to reimburse drug administration APCs at 40% of the OPPS rate. This payment cut coupled with an inadequate market basket update will make it harder for hospitals to sustain essential outpatient services in communities across New York and the country. If CMS moves forward with this proposal, we ask that CMS continue to exempt rural sole community hospitals in addition to other rural hospitals including Medicare Dependent Hospitals and Rural Emergency Hospitals.

Request for information – future site-neutral policies

CMS is seeking feedback for future rulemaking on the development of a more systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity. Specifically, CMS is seeking feedback on expanding the site-neutral payment cuts to on-campus clinic visits and aligning OPPS payments with those services predominately performed in a lower-cost setting such as an ASC or physician office.

HOPDs are a principal source of patient care and in some areas of New York are the only source of primary care and other physician services. Hospitals and their HOPDs care for more clinically complex and vulnerable populations than independent physician offices and ASCs, while facing more requirements. Further neutralizing payments among these settings is inappropriate and will make it harder for HOPDs to sustain essential services. **HANYS strongly opposes any future site-neutral payment policies that would further reduce reimbursement to hospitals and health systems, threatening access to care in communities.**

Inpatient-only list

The inpatient-only list was created in 2000 to identify procedures that would need more than 24 hours of stay to recover. Currently, there are 1,731 procedures on CMS' inpatient-only list, which are reviewed and updated annually. However, over the years, CMS has removed many high-profile procedures from the list, including total knee arthroplasty and total hip arthroplasty, which would allow for Medicare coverage of these procedures in either an inpatient or outpatient setting. In this rule, CMS is proposing to eliminate the IPO list over the next three years, with full elimination by 2029. For 2026, CMS is proposing to remove 285 mostly musculoskeletal procedures from the IPO list.

HANYS is concerned about CMS' proposal to eliminate the IPO list, which was put into place to protect beneficiaries. Due to the depth and breadth of the services on the IPO list, **HANYS aligns with the AHA and recommends that CMS not move forward with the full elimination of the IPO list but instead continue its standard process for removing procedures from it.** The appropriate setting for a procedure should be determined with a careful focus on patient safety and peer-reviewed evidence.

CMS' proposal to broadly remove procedures from the IPO list raises serious patient safety and clinical appropriateness concerns. Specifically:

- *Lack of clinical review*: The proposal applies a blanket policy without evaluating the safety or clinical implications of shifting complex procedures to outpatient settings.
- *High-risk procedures*: Many procedures on the IPO list may never be appropriate to furnish in a hospital outpatient setting, such as heart-lung transplants (CPT codes 33935 and 32853),

radical mastectomies (CPT code 19306) and multi-vessel coronary bypass surgeries (CPT code 33523) because they are inherently high-risk and require inpatient care due to their complexity and extended recovery needs.

- *Insufficient data for musculoskeletal procedures*: Among the 285 musculoskeletal procedures proposed for removal in FFY 2026, several lack adequate evidence supporting their safety in outpatient or ASC settings, such as hand replantation, radical sternum resection and major amputations, which are considered high-risk procedures that require more than 24 hours of recovery or monitoring time.
- *Quality of care risks*: Removing these procedures from the IPO list and allowing them in ASCs could jeopardize care quality for vulnerable Medicare patients, given the need for more than 24 hours of postoperative monitoring and specialized inpatient support.

For these reasons, HANYS strongly urges CMS to withdraw its proposal to eliminate the IPO list and remove 285 procedures in CY 2026. Many of the services on the IPO list involve complex and invasive surgical procedures that may necessitate extended hospital stays, stringent infection control measures and substantial rehabilitation and recovery time — requiring the comprehensive, coordinated care available only in an inpatient hospital setting.

Furthermore, as healthcare providers nationwide continue to face substantial cost increases, fully eliminating the IPO list would further intensify the financial strain on hospitals by shifting procedures from the inpatient setting to the outpatient setting for reimbursement purposes.

Lastly, CMS is also proposing to continue to provide an indefinite exemption from site-of-service claim denials, Beneficiary Family Centered Care-Quality Improvement Organization referrals to Medicare Recovery Audit Contractors and Recovery Audit Contractor patient status reviews for procedures removed from the IPO list. **HANYS supports CMS' proposal to provide an indefinite exemption until the secretary determines that the exemption is no longer appropriate and can be performed safely in the outpatient setting.**

While we agree that it's important for a physician to use their clinical knowledge and judgement together with consideration of a patient's specific needs to determine the appropriate setting for the procedure to be performed in, the current patient status review process could pose obstacles during a review if a procedure was never done in the outpatient setting and the physician believes it should be done in an inpatient setting regardless of whether the patient meets the two-midnight rule criteria.

340B remedy budget neutrality adjustment

In 2023, CMS issued a 340B remedy final rule which provided lump-sum payments to 340B hospitals for the loss of payments during CYs 2018-2022. To maintain budget neutrality, CMS finalized in the remedy rule a 0.5% annual reduction to the conversion factor for non-drug items and services, effective CY 2026 over 16 years or until the estimated $7.8 billion in overpayments was recouped. In this rule, CMS proposes to increase the 340B remedy budget neutrality payment adjustment from 0.5% to 2.0% beginning in CY 2026 over six years or until CMS recoups $7.8 billion. As in prior comments, **HANYS aligns with the AHA and urges CMS to rescind its proposal to expedite the clawback of the budget neutrality adjustment under §419.32(b)(1)(iv)(B)*(12)* altogether because the agency lacks the statutory authority for any such clawback on any timeline**.

If CMS persists with this unlawful clawback, it should *not* accelerate the existing timeline. When it codified a 16-year timeline in the 340B Final Remedy Rule, CMS stated that it sought to "comply with the statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities." In suddenly changing course, CMS now asserts that it "insufficiently accounted for" what it calls the "main

premise of the Final Remedy rule" — the need to return 340B hospitals to the financial position they would have been if CMS never implemented its illegal policy in the first place. According to the proposed rule, a six-year timeframe "better balances that goal and [its] budget neutrality obligations against hospital burden and reliance interests."

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

Our hospitals have already started to make budget decisions based on the 0.5% payment adjustment as finalized in the 340B remedy rule. It therefore makes no difference that those rate reductions have not yet gone into effect. If the agency finalizes this unexpected increase from 0.5% to 2.0% just months before they take effect, the budgets produced based on that 0.5% figure will be thrown out of whack, upsetting settled expectations with little time to readjust and creating serious cash flow problems. That is the paradigmatic reliance interest, and the agency is wrong to state that those interests are "minimal."

Second, CMS must also better account for the burden the proposed accelerated timeline will inflict on hospitals nationwide. An annual increase from 0.5% to 2.0% will meaningfully impact our New York state hospital total Medicare margins, which are already negative 22.5%, based on 2023 claims data.

In addition, the agency's balancing fails to account for adverse financial trends since 2023. As a general matter, New York hospitals and health systems have experienced cost increases and are continuing to trend in the wrong direction. Like all hospitals, our government reimbursements continue to remain inadequate. Also like other hospitals, shifts in care patterns will present us with older, sicker populations with more complex, chronic conditions that require more costly care. The proposed rule *nowhere* considers the recent passage of the *One Big Beautiful Bill Act*, which will have direct, adverse impacts on our hospital's finances. Accordingly, if the agency is trying to balance its purported "budget neutrality obligations against hospital burden and reliance interests," it cannot ignore the effects of the OBBBA or these other financial trends.

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

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

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

340B acquisition survey

CMS is proposing its intent to conduct a hospital acquisition cost survey for each separately payable drug acquired by all hospitals paid under the OPPS in early CY 2026. CMS also intends to propose Part B drug payment policies based on the results of this survey for setting the CY 2027 OPPS rates.

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

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

Ultimately, however, the main reason for abandoning this proposed cost acquisition survey is that its eventual goal should never be pursued. CMS appears to be conducting this survey in service of reducing Medicare reimbursements in CY 2027 and beyond. But Medicare payments *already* lag far behind the costs hospitals incur for providing care to Medicare beneficiaries. Medicare reimbursement covers just 89 cents for every dollar spent by hospitals. From 2022 to 2024, general inflation rose by 14.1%, while Medicare net inpatient payment rates increased by only 5.1% — amounting to an effective payment *cut* over the past three years. In December 2024, the Medicare Payment Advisory Commission noted in a preliminary presentation to commissioners that hospital Medicare margins had sunk to an all-time low of negative 12.6% and were projected to remain at that level in 2025.

An additional Medicare cut resulting from this proposed survey would be unsustainable. **Thus, if the goal of this survey is to cut Medicare payments, the survey should not be conducted at all**.

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

Second, perhaps recognizing that it does not have the legal authority to require a survey response, the agency "welcome[s] comment on how we might propose to interpret non-responses to the

survey." The proposed rule includes four options that the agency could use to interpret a hospital's non-response to its survey. *None of these options* would satisfy the statutory requirement that a survey "…have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug." **Put simply, the agency cannot contrive responses where there are none and then claim that there is a large enough sample size.** Further, the agency's provided interpretations of non-responses would yield inaccurate data that are in no way "statistically significant." **If the agency is concerned about the lack of responses from hospitals, it should not issue a survey in the first place.**

Price transparency

CMS proposes changes to hospital price transparency requirements, particularly around machine-readable files and enforcement. While some refinements are helpful, CMS should prioritize future initiatives that most effectively support patients in understanding and comparing their anticipated costs before receiving care rather than adding administrative burdens.

Attestation concerns

CMS proposes revising the machine-readable file attestation language to require hospitals to affirm they've provided "all necessary information" for the public to determine service prices. This is unrealistic given the complexity of hospital billing, which heavily depends on insurer behavior and other variables. **HANYS aligns with the AHA and urges CMS to retain the current "good faith effort" attestation, which better reflects what hospitals can realistically provide.**

Additionally, CMS proposes to require CEOs or senior executives to sign the attestation, which is unnecessarily burdensome. CMS should trust the good faith of other staff closer to the data who are better positioned to verify accuracy rather than someone higher on the organizational chart with broader responsibility**. We recommend CMS maintain flexibility and avoid finalizing this proposal to require CEOs or senior executives to attest to the accuracy and completeness of the data.**

Allowed amount data elements

Beginning Jan. 1, 2026, CMS proposes requiring several new machine-related data elements in cases when payer-specific negotiated charges are based on a percentage or algorithm. Specifically, CMS would require hospitals to publish the median, 10th percentile and 90th percentile allowed amounts, plus a count of the claims used for the calculations.

We have several concerns regarding the methodology, and we refer CMS to the comments from the AHA regarding issues related to patient privacy, the lookback period for data and the methodology for calculating medians and percentiles. **We urge CMS not to adopt this proposal. If CMS moves forward, we strongly request that the agency allow hospitals at least one year to adopt the new data elements.** At a time when hospital resources are stretched thin, we are concerned about the additional burden the new requirements would place on our hospitals, especially given the short timeline for implementation.

National provider identifiers

CMS proposes requiring hospitals to include National Provider Identifiers in machine-readable files to improve pricing data usability and interoperability. However, encoding Type 2 NPIs adds technical and operational complexity — especially when combined with other new CMS requirements, such as using algorithms or percentages to encode payer-specific negotiated charges, calculating and

reporting estimated allowed amounts, and attesting to the accuracy and completeness of all data elements.

Additionally, many hospital-payer contracts include confidentiality clauses. Including NPIs alongside detailed pricing data could expose specific contracting arrangements, increasing the risk of legal disputes. For these reasons, **HANYs asks that CMS withdraw its proposal to require NPI in the machine-readable files.**

However, if CMS proceeds with its proposal, HANYS would urge the agency to ensure that the reporting of NPIs does not contribute to unnecessary complexity or administrative burden. As CMS considers further enhancements to machine-readable file requirements, we recommend a coordinated approach that streamlines data elements across both hospital and insurer files. This will help ensure that transparency efforts remain focused on delivering actionable, meaningful information to patients and purchasers.

Price transparency alignment

HANYS appreciates CMS' recognition of the several overlapping federal price transparency policies and interest in how changes to the hospital price transparency requirements could help achieve alignment. While hospitals are dedicated to improving price transparency for patients, concerns remain that the numerous and sometimes conflicting requirements at both the state and federal level create an overwhelming landscape of pricing information that is not only challenging for patients to navigate but also adds excessive costs and workforce burden to the healthcare system. **HANYS strongly recommends CMS focus on streamlining current policies to remove complexity from the patient experience by narrowing the options for patient estimates and other pricing information and ensuring those estimates are as accurate as possible**. This will also minimize duplication and excess burden on the healthcare system.

Hospital quality star reporting methodology

As in prior comments, HANYS has expressed our longstanding concerns with the Overall Star Ratings methodology, which oversimplifies the complexity of delivering high-quality care. Combining the process of care and outcome measures into a star rating does not give patients the information they need to make a fully informed decision about their care.

CMS' analysis of the July 2024 Overall Star Ratings revealed a strong link between hospital performance on safety measures and their Overall Star Rating — hospitals with better safety scores generally received higher ratings. However, 14 hospitals (0.5%) received a five-star rating despite scoring in the bottom quartile for the Safety of Care measure group. CMS concluded that this indicates a hospital can be rated highly while still delivering unsafe care and therefore proposes a methodological change to give greater weight to safety measures in future ratings.

To address this issue, CMS is proposing a two-stage framework within the Hospital Quality Overall Star Ratings methodology to better account for performance in the Safety of Care measure group. This approach is intended to ensure that safety outcomes have a more significant influence on a hospital's overall rating. CMS is proposing the following:

- Stage 1: For CY 2026, limit hospitals in the lowest-performing quartile of the Safety of Care measure group to a maximum of 4 stars; and

- Stage 2: Beginning in CY 2027, implement a blanket 1-star reduction for hospitals in the lowest-performing quartile of the Safety of Care measure group.

While the proposed Stage 1 approach will have no effect on our New York hospitals, our data review shows that the Stage 2 approach will impact ~16.5% of our hospitals, compared to 10.1% for the nation. The Stage 2 approach will be a major swing in ratings for consumers who may not appreciate why a provider's star rating has declined. CMS already designed a payment policy around bottom-quartile performance on safety measures, such as the hospital-acquired conditions reduction program, which provides a financial incentive for improvement. Further penalizing hospitals reputationally may deteriorate what the agency is trying to improve or incentivize.

While prioritizing patient safety is important, modifying the methodology behind the Overall Star Rating, rather than improving how safety is actually evaluated, gives undue significance to the rating itself. The rating alone doesn't determine which hospitals are safest, so adjusting it to favor certain groups doesn't necessarily make those hospitals safer. **HANYS urges CMS to reject these proposed methodological changes to the Overall Star Ratings**.

Hospital outpatient quality reporting program

Emergency Care Access & Timeliness eCQM

CMS proposes adopting the Emergency Care Access & Timeliness eCQM, a new composite measure that tracks four key metrics of emergency department efficiency. **While HANYS fully supports improving patient access to emergency care, we believe the proposed ECAT eCQM is fundamentally flawed: it's a composite that dilutes critical data; it unfairly penalizes hospitals for issues beyond their control; and it could compromise patient care**.

Flawed composite measure and diluted data

HANYS has consistently voiced our opposition to composite quality measures. By blending four distinct metrics, the ECAT eCQM masks performance on individual measures. A hospital could have a high number of patients leaving without being seen — a critical safety issue — but this problem could be obscured by strong performance in the other three areas. The current individual measures, such as "Median Time from ED Arrival to ED Departure" and "Left Without Being Seen," provide clear, actionable data. **HANYS believes replacing them with a less transparent composite measure will hinder genuine quality improvement.**

Punishing hospitals for systemic failures

Issues the ECAT eCQM aims to track — specifically prolonged ED boarding and excessive length of stay — are a direct result of systemic problems outside the ED's control. The primary driver of ED congestion is often the lack of inpatient beds, a broader hospital capacity issue. **HANYS believes this measure would financially penalize hospitals that are already underfunded and struggling with capacity and would not solve the underlying systemic issues.**

Unintended consequences for patient care

Our ED physician members have provided strong feedback that this measure will likely create unintended negative consequences. Rather than promoting high-quality care, it could incentivize EDs to prioritize speed over safety to avoid financial penalties. This could create a "Hawthorne effect," where the metric becomes the primary goal. As a result, providers might be pressured to take

shortcuts, provide rushed or lower-quality care, or even use alternative diagnostic codes to sidestep metrics for complex cases, such as those involving behavioral health. The measure's emphasis on speed over substantive quality could, in the end, lead to worse patient outcomes.

HANYS strongly recommends that CMS not adopt the ECAT eCQM in the Outpatient and Rural Emergency Hospital quality reporting programs. Instead, we urge CMS to work with stakeholders to develop alternative solutions that address the underlying systemic failures contributing to ED inefficiency and ensure that quality measures promote safe, effective patient care, not just speed.

Excessive Radiation eCQM

CMS is proposing to maintain voluntary reporting of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults" eCQM. While HANYS appreciates this shift to voluntary reporting, we believe this action is insufficient given the measure's fundamental flaws. **Instead of making a problematic measure voluntary, HANYS urges CMS to remove it entirely from all quality programs.**

The measure suffers from significant issues and ambiguities that have been well-documented by leading professional societies. Its continued presence, even as a voluntary option, creates unnecessary technical complexity, cost and burden without providing a valid measure of quality.

Leading professional organizations have voiced strong opposition, including the American Association of Physicists in Medicine and the American College of Radiology. As detailed in a publication in the *American Journal of Roentgenology,*[5] an expert panel convened by the AAPM identified 20 issues and ambiguities in the measure's specifications.

Given these critical issues, HANYS recommends removing the measure entirely from all quality programs. This would allow for the development of a scientifically sound and practical alternative in collaboration with clinical and technical experts. This would better align CMS' quality reporting with meaningful improvements in patient care while reducing undue burdens on the healthcare system.

Ambulatory Surgical Center QRP

CMS is proposing to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery and Patient Reported Outcome-Based Performance measures under the ASC QRP. While HANYS appreciates CMS' goal of improving patient understanding, we have serious concerns about the proposed Information Transfer PRO-PM, as follows:

- *Flawed measure design*: This nine-item survey measures service delivery, not patient health outcomes, and is unlikely to inform clinical decision-making. Its potential overlap with the OAS CAHPS survey may confuse patients and cause survey fatigue.
- *Unreliable data*: Barriers like limited internet access, technology and language will lead to low participation and unrepresentative data that does not reflect the entire patient population.
- *Unnecessary burden*: The measure's administrative tasks, including data collection and tracking, significantly burden facilities with existing staff shortages. This diverts resources from direct patient care, contradicting CMS' claim of minimal burden.

[5] *American Journal of Roentgenology* https://pubmed.ncbi.nlm.nih.gov/40008834/

HANYS urges CMS not to adopt this measure. HANYS supports the pre-rulemaking review committee's position that consensus was not reached and that the measure requires further development. **HANYS recommends that CMS first align the survey with the OAS CAHPS survey and conduct additional testing in ASCs before considering its implementation.**

Market-based rates under the Inpatient PPS

CMS is proposing that hospitals would be required to report their median Medicare Advantage Organization-specific negotiated charges by Medicare-Severity Diagnosis-Related Groups as disclosed in the most recent hospital price transparency machine-readable file on their Medicare cost report beginning on or after Jan. 1, 2026. CMS proposes to use this data beginning in FFY 2029 to calculate the IPPS MS-DRG relative weights to reflect relative market-based pricing.

HANYS aligns with AHA's view that, if finalized, the proposal would be arbitrary and capricious because CMS cannot sufficiently explain the dramatic potential shift in regulatory framework. In addition, the proposal is likely not authorized by the cited statutory authority and is precluded by other existing statutory requirements.

As set forth in Section 1886(d)(4)(A) of the Social Security Act, relative weights are intended to reflect "the relative hospital resources used with respect to discharges classified within that group" and not the relative price paid. CMS currently uses "*a cost-based methodology to estimate an appropriate weight for each MS–DRG*." In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than cost is a better measure of hospital resources used. Instead, the agency appears to conflate market price with cost.

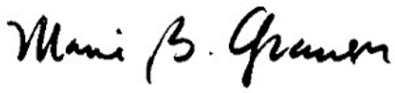
In addition, CMS is unable to assess the effects of its proposed policy since the underlying data are not currently maintained in the format the agency would require.

Finally, most MA markets lack true competition, as they are often dominated by one or two insurers. This undermines the validity of using these rates to set Medicare fee-for-service MS-DRG relative weights.

For these reasons, HANYS strongly urges CMS to withdraw its proposal.

Thank you for the opportunity to comment. If you have questions, please contact Kevin Krawiecki, vice president, fiscal policy, at kkrawiec@hanys.org or 518.431.7634.

Sincerely,



Marie B. Grause, RN, JD
President