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August 31, 2026

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

RE: CMS-1850-P: Medicare Program; Hospital Outpatient Prospective Payment System for Calendar Year 2027; 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 proposed Outpatient Prospective Payment System rule for calendar year 2027. Our comments are arranged by topic area below.

Inadequate payment update

For CY 2027, CMS proposes a 2.4% payment update for hospitals, inclusive of a 3.2% market basket update and a 0.8 percentage point reduction for productivity mandated by the *Affordable Care Act*. **Amid ongoing financial pressures, hospitals are already making difficult decisions to preserve services in their communities. This concerning and inadequate payment update would exacerbate these pressures.**

In particular, the 0.8 percentage point reduction to the market basket for productivity could not have anticipated the extraordinary cost and affordability pressures that hospitals continue to face. The productivity adjustment is intended to reflect a provider's ability to absorb a portion of input cost growth through efficiency gains. However, that assumption does not reflect the realities of acute hospital care delivery. Hospitals operate in a labor-intensive, high-acuity environment where the need to maintain around-the-clock emergency, trauma and specialty capacity sharply limit opportunities to offset cost growth through productivity gains.

In addition, the proposed 3.2% market basket update does not sufficiently account for ongoing workforce shortages, elevated labor costs and inflationary pressures for medical supplies and pharmaceuticals that our hospitals continue to face.

Hospitals also face financial uncertainty associated with substantial federal healthcare funding reductions that are expected to increase uncompensated care and further strain hospital resources. CMS should ensure the final payment update more accurately reflects current cost pressures so hospitals can sustain high-quality care and preserve beneficiary access to essential services.

HANYS urges CMS to evaluate all available data sources and policy options to ensure the CY 2027 update more accurately reflects acute care hospitals' actual cost experience. At a minimum, CMS could waive the application of the 0.8 percentage point productivity adjustment using its "special exceptions and adjustments" authority for CY 2027. Absent such action, a reduced OPPS payment update would further widen the gap between Medicare payment and the actual cost of furnishing care.

340B payment reduction

Based on the results of CMS' recent OPPS Drug Acquisition Cost Survey, the agency proposes to reduce OPPS payments for drugs furnished under the 340B Drug Pricing Program from average sales price plus 6% to ASP minus 33.4% beginning in CY 2027. **HANYS strongly opposes CMS' proposal to drastically reduce this Medicare reimbursement by nearly 40%.** This payment reduction would begin just as hospitals are beginning to absorb the financial effects of the *One Big Beautiful Bill Act,* which will reduce coverage, shift costs onto providers, erode critical revenue streams and increase uncompensated care throughout the healthcare continuum. **In alignment with the American Hospital Association's comments, HANYS urges CMS to abandon this proposal altogether.**

CMS has not demonstrated that the ODACS satisfies the statute's requirement for a statistically significant estimate of the average hospital acquisition cost for each covered outpatient drug. Section 1833(t)(14)(D)(iii) requires CMS to 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*." CMS' overall response rate was only 43% and the response rate among 340B hospitals was just 28.6%. This limited response creates significant risk of nonresponse bias and does not provide a sufficiently sound basis for extrapolating a national payment policy that would reduce reimbursement by nearly 40%.

Moreover, CMS appears to rely on an aggregate margin across drugs, rather than demonstrating statistically significant estimates at the individual drug level as required by statute. CMS acknowledges that the number of hospital observations varies across National Drug Codes and that its methodology for identifying outliers could not be applied to NDCs for which fewer than 10 hospitals reported purchases. Yet CMS' reported confidence intervals address the aggregate acquisition cost margin; they do not demonstrate that the statutory standard has been satisfied for each individual drug. An aggregate finding of statistical significance cannot substitute for the drug-specific estimates expressly required by statute.

Given the significant payment consequences of the proposal, HANYS urges CMS not to rely on an aggregate survey result to satisfy a statutory requirement that expressly calls for statistically significant estimates for each drug.

Recent Health Resources and Services Administration policy decisions impose other significant costs on 340B hospitals. For example, HRSA is pursuing a misguided Rebate Model Pilot Program that will inflict massive administrative costs, "float costs" and non-economic costs on 340B hospitals. As the AHA has explained, the rebate program will cost 340B hospitals more than a billion dollars annually. HRSA is also permitting drug manufacturers, including Eli Lilly, to impose unlawful, onerous and expensive claims data requirements on hospitals, just so that they can receive discounts they are already owed by statute.

HANYS urges CMS to consider the cumulative impact of these harmful policies before moving forward with its proposed nearly 40% reduction for 340B drugs. CMS is not required to finalize this payment reduction and should abandon it.

Any payment reduction of this magnitude would have significant consequences for safety net hospitals that rely on the 340B program to stretch scarce resources and maintain services for low-income and other vulnerable patients. In New York, 340B hospitals as a group currently have a very thin operating margin (1.2%), with many individual hospitals suffering from persistent negative margins. These financial pressures make it increasingly difficult for hospitals to maintain facilities, invest in services and preserve access to care.

340B discounts enable safety net hospitals to offset chronic underpayments from public payers such as Medicaid and support programs and services that otherwise may not be financially viable. HANYS' member hospitals report using 340B savings to support:

- free or substantially discounted prescriptions to uninsured or low-income patients;
- medication therapy management programs to improve patient care and reduce overall healthcare costs and hospital readmissions;
- mobile units to bring care to rural and other medically under-served communities without local primary care options or pharmacies;
- free oncology services to low-income patients;
- HIV/AIDS clinics;
- diabetes management programs;
- multidisciplinary clinics offering substance abuse and mental health needs; and
- transportation support to patients who need to use emergency room services.

While doing nothing to address rising drug prices, CMS' proposal would instead reduce resources available to IPPSsafety net hospitals and put these programs and services at risk. This proposal would simply function as a significant Medicare payment cut for 340B hospitals that care for vulnerable populations. **HANYS strongly urges CMS to abandon its proposal.**

However, **if CMS moves forward with such a policy despite our strong opposition, we urge the agency to consider the following changes:**

- add back the 6% add-on payment for overhead and handling costs;
- abandon the mandatory use of billing modifiers;
- exempt drugs that are in shortage;
- maintain exemptions for rural sole Community Hospitals, Critical Access Hospitals, children's hospitals and PPS-exempt cancer hospitals; and
- exclude non-excepted off-campus provider-based departments since they are paid under the Medicare Physician Fee Schedule.

340B remedy budget neutrality adjustment

In 2023, CMS issued a 340B remedy final rule that provided lump-sum payments to 340B hospitals for the loss of payments during CYs 2018 to 2022. To maintain budget neutrality, CMS finalized in the 340B 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. CMS' proposed rule would increase the 340B remedy budget neutrality payment adjustment from 0.5% to 3.0% beginning in CY 2027 with full recoupment of the $7.8 billion by the end of CY 2029.

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.**

When CMS established the 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 now proposing to dramatically accelerate that timeline, CMS asserts that it "insufficiently accounted for" what it describes as the "main premise of the Final Remedy rule"— the need to return 340B hospitals to the financial position they would have been in had CMS never implemented its unlawful payment policy.

However, CMS has not adequately accounted for the significant financial burden that the proposed accelerated recoupment would impose on hospitals nationwide. Like all hospitals nationally, our New York hospitals continue to face inadequate government reimbursement while simultaneously experiencing shifts in care patterns that are resulting in older, sicker patient populations with more complex and chronic conditions requiring increasingly costly care.

Moreover, the accelerated recoupment would begin just as hospitals are beginning to absorb the financial effects of the *One Big Beautiful Bill Act,* which will reduce coverage, shift costs onto providers, erode critical revenue streams and increase uncompensated care throughout the healthcare continuum. The proposed rule does not meaningfully consider the cumulative impact of imposing an accelerated clawback on hospitals at a time when they are already facing significant financial pressures.

The proposed acceleration would have a meaningful adverse impact on New York hospitals' operating margins, with most hospitals operating at a loss or barely breaking even.[1] **HANYS strongly urges CMS to account for these substantial costs and burdens before imposing an accelerated recoupment schedule, particularly when CMS itself previously recognized the importance of avoiding an overly burdensome offset.**

Ultimately, hospitals should not be made to bear the consequences of CMS' reimbursement cut that the Supreme Court unanimously held unlawful in *American Hospital Association v. Becerra*. Hospitals that would be subject to the clawback could not have declined any additional payments even if they had wanted to. Hospitals should not be punished for CMS' past mistakes and be subject to an arbitrary and substantial cut at a time when their finances are already being squeezed by rising costs, inadequate Medicare and Medicaid reimbursement and other federal policy decisions.

HANYS continues to object to CMS' budget neutrality clawback because the agency lacks statutory authority to impose such a recoupment on any timeline. At a minimum, if CMS declines to rescind the adjustment altogether, it should not finalize the proposed acceleration and should retain the existing 0.5% budget neutrality adjustment rather than increasing the reduction to 3.0%.

Site-neutral payment reductions

Currently, CMS applies physician fee schedule-equivalent payment to general clinic visit services (HCPCS G0463) and drug administration services furnished in excepted off-campus provider-based departments under its volume-control authority in Section 1833(t)(2)(F) of the Social Security Act. Non-excepted off-campus PBDs already receive PFS-equivalent payment under Section 603 of the

[1] HANYS (2025) New York State Hospitals Fiscal Survey Report. https://www.hanys.org/communications/publications/2025/new-york-state-hospitals-fiscal-survey-report-nov-2025.pdf

Bipartisan Budget Act of 2015. For CY 2027, CMS proposes to expand the site-neutral payment cuts to include all imaging without contrast services assigned to APCs 5521-5524 and three composite APCS 8004, 8005 and 8007 for excepted off-campus PBDs. **HANYS strongly opposes any payment rate cuts for excepted off-campus PBD sites, including an expansion to include imaging without contrast.**

While Section 603 of the BBA clearly protects off-campus PBDs billing for Medicare 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."

However, the proposed rule does not adequately account for the statutory distinction Congress established in Section 603. CMS proposes to further extend PFS-equivalent payment to excepted off-campus PBDs, notwithstanding that Congress expressly distinguished those departments from non-excepted PBDs. Although CMS has previously applied this methodology to clinic visits and drug administration services, its continued expansion raises concerns about the significance of Congress' distinction between excepted and non-excepted PBDs. CMS must explain how extending this methodology to additional services is consistent with the statutory framework established by Section 603.

In addition, CMS has not adequately demonstrated that payment differentials are driving unnecessary migration of imaging services to hospital outpatient departments. Instead, CMS should consider whether any observed growth reflects legitimate differences in patient populations, referral patterns, access to care and the availability of hospital-based clinical resources.

HANYS disagrees with CMS' conclusion that higher OPPS payments are causing hospitals to acquire independent physician practices or otherwise generate an "unnecessary increase in the volume of services." That conclusion overlooks the significant pressures facing physician practices, including inadequate reimbursement, rising practice expenses, physician workforce shortages, administrative and compliance burdens, and the growing need for integrated clinical support for patients with complex conditions. In many communities, hospital affiliation has helped preserve access to outpatient care that otherwise may have been reduced or lost.

CMS acknowledges that provider-based HOPDs serve unique and medically complex patient populations. However, its analysis focuses too narrowly on the higher risk scores for imaging services performed without contrast in provider-based HOPDs compared with physician offices and concludes that differences in patient severity do not justify higher OPPS payments. This approach overlooks broader differences in patient needs, hospital-based resources and the role of imaging as a gateway diagnostic service for older adults who may require coordinated follow-up care.

Reducing payment for imaging without contrast in excepted off-campus PBDs could jeopardize community-based outpatient imaging capacity, especially in rural, low-income and medically underserved areas with limited alternatives, leading to longer travel, delayed diagnoses and greater pressure on emergency departments. The relevant distinction is not simply the imaging service itself, but the clinical environment in which it is furnished.

CMS should therefore reconsider its conclusion that the growth in imaging without contrast services necessarily represents unnecessary utilization driven by payment incentives. A broad payment reduction based primarily on site of service is not a targeted response to unnecessary volume. **For these reasons, HANYS strongly urges CMS to withdraw its proposal to reimburse imaging without contrast APCs at 40% of the OPPS rate.**

This payment reduction, coupled with an inadequate market basket update, the nearly 40% cut for drugs furnished under the 340B program, the proposed acceleration of the 340B remedy budget neutrality adjustment and other federal policy changes, including the *One Big Beautiful Bill Act,* would materially reduce outpatient reimbursement. This would 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, **HANYS urges CMS to retain the proposed exemption for rural Sole Community Hospitals and extend the exemption to other rural hospitals, including Medicare-Dependent Hospitals and Rural Emergency Hospitals**.

National Provider Identifier

The *Consolidated Appropriations Act of 2026* requires hospitals to obtain and bill under a separate National Provider Identifier for each off-campus provider-based hospital outpatient department beginning Jan. 1, 2028.

HANYS recognizes that CMS is implementing the statutory requirement enacted by Congress. However, CMS has significant discretion in how this requirement is operationalized. As proposed, the policy would introduce substantial complexity by requiring hospitals to navigate an environment in which some health plans use a centralized billing NPI while others, including CMS, use the location-specific NPI for the off-campus provider-based HOPDs. This approach would increase administrative burden and create several operational issues that are not addressed in the proposed rule, such as:

Department vs. address. The proposed use of the term "department" raises significant concerns and can be interpreted to mean each clinical service line, cost center or hospital department within an off-campus facility. A single off-campus provider-based HOPD may house multiple provider-based services. Requiring a separate NPI for each could create unnecessary complexity for patients, payers, referring physicians, claims systems, provider directories, enrollment records and compliance processes. More importantly, it could create a significant administrative burden to operationalize.

CMS regional staff stated that the NPI assignment would be based on how the site is designated in the Provider Enrollment, Chain and Ownership System — so if multiple off-campus PBDs have the same address in PECOS only one NPI would be required. However, if multiple off-campus PBDs are located at the same address but have separate identifiers such as room numbers or suite numbers assigned in PECOS, that would require a separate NPI for each off-campus PBD. **HANYS urges CMS to provide clarity on this distinction in the final rule so hospitals can obtain NPIs accordingly either by the physical address level, based on how the location is designated in PECOS or at each individual department**.

Coordination of benefits. The proposed rule could require hospitals to bill the same location under different NPIs depending on the payer. This creates significant coordination of benefits concerns because COB depends on accurate matching of provider identifiers, claims, payer responsibility and remittance information.

For example, if a commercial plan processes a claim under the hospital's existing centralized NPI while Medicare receives a crossover or secondary claim under a department-specific NPI, the mismatch could result in rejections, duplicate provider records, inappropriate denials and increased manual reconciliation. **HANYS urges CMS to provide clear COB guidance in the final rule to ensure the new NPI requirement does not disrupt claims processing or payment.**

Professional claims. The proposed requirement could affect professional claims because physicians and other practitioners generally report a facility or service-location NPI. If professional claims continue to use a hospital's centralized NPI while facility claims use a new department-specific NPI, payers may have difficulty matching the professional and institutional components of the same service. This could result in denials, payment delays, additional documentation requests and beneficiary confusion. **HANYS urges CMS to clarify professional claim billing alignment so the NPI policy does not disrupt claims matching or payment.**

Beyond these specific operational challenges, the proposed rule also raises broader concerns about consistency with the administrative simplification policy and the potential downstream effects on payer processes such as prior authorization.

Administrative simplification. The *Health Insurance Portability and Accountability Act* administrative simplification provisions were designed to standardize electronic healthcare transactions and reduce administrative costs associated with payer-specific requirements. CMS subsequently adopted NPI as the standard to replace multiple provider identifiers and allow providers to use a single uniform identifier for use across all claims, regardless of insurer.

Requiring distinct NPIs for each off-campus PBD for Medicare purposes would move in the opposite direction, undercutting the efforts of the HIPAA simplification goals by creating payer-specific identifier requirements and requiring hospitals to maintain different billing identifiers for the same site of care. Hospitals and health systems would need to update enrollment records, patient accounting systems, claims edits, payer crosswalks, contracting files, provider directories, prior authorization workflows and reporting systems. **HANYS urges CMS to minimize administrative burden by establishing uniform national implementation guidance that avoids payer-specific variation and prevents unnecessary denials and payment delays.**

Prior authorization. Although traditional Medicare uses prior authorization only in limited circumstances, the proposed NPI structure could create issues if Medicare Advantage, Medicaid or commercial payers adopt a similar approach. Prior authorization systems are often tied to billing or servicing NPIs. Different NPIs for different locations could require hospitals to obtain or update authorizations when patients receive care at another location, even when the physician, diagnosis, treatment plan and hospital system remain unchanged. This could create unnecessary denials or authorization corrections and is particularly concerning for recurring or time-sensitive services such as chemotherapy and radiation oncology. Administrative delays could disrupt access to medically necessary care. **HANYS urges CMS to ensure that beneficiaries are not harmed by administrative delays in prior authorization.**

In light of these concerns and the statutory requirement under the CAA of 2026 to obtain and bill a unique NPI by Jan. 1, 2028, **HANYS encourages CMS to use the intervening period to provide clear definitions, detailed operational guidance and robust stakeholder engagement to ensure hospitals can comply without unnecessary disruption.**

Provider-based attestations

The CAA of 2026 requires hospitals with off-campus HOPDs to submit periodic attestations demonstrating continued compliance with the provider-based requirements at 42 CFR § 413.65 as a condition of payment beginning Jan. 1, 2028. HANYS appreciates CMS' efforts to implement these provider-based attestation requirements. While we support the development of a standardized attestation process, **we urge CMS to adopt policies that streamline compliance, avoid duplicative**

reporting and documentation requirements, provide reasonable operational flexibility and ensure that compliant hospitals are not subject to payment interruptions due to technical or administrative issues.

Standardized attestation form

HANYS appreciates CMS' draft standardized attestation form and generally supports its format and content. The unified electronic form would replace the existing Medicare Administrative Contractor-specific templates and provide clear yes, no and not applicable checkbox affirmations for each provider-based requirement.

However, CMS' proposal requires that the attestation form be signed with an original ink signature and dated by an authorized PECOS-registered official of the main provider. This would create a significant administrative burden for hospitals and health systems that have numerous off-campus PBDs. To reduce this burden, **HANYS urges CMS to permit electronic signatures in lieu of the original ink signature and allow the authorized official to designate one or more authorized submitters to submit attestations on an official's behalf.**

Attestation requirements

CMS seeks comments on initial attestations for hospitals with off-campus provider-based departments that received a CMS determination of provider-based status prior to Jan. 1, 2026, and remain in compliance. **HANYS urges CMS to allow these existing CMS determinations to satisfy the initial attestation requirements, provided the hospital certifies that the department continues to meet the provider-based requirements.**

CMS proposes to require subsequent attestations within five years. **HANYS urges CMS to use the full five-year interval for subsequent attestations and establish a streamlined renewal process.** More frequent attestations would create substantial recurring administrative burden without a commensurate program integrity benefit.

CMS proposes using risk-based screening to identify attestations that may require additional documentation. **HANYS recommends CMS establish uniform national documentation and review standards to prevent inconsistent requirements among MACs.** In addition, documentation applicable to multiple PBDs should be permitted to be submitted once and referenced for other departments, where applicable.

Lastly, CMS proposes that a denial would be issued if an attestation fails to demonstrate compliance or if a provider fails to furnish requested information or attest to all applicable requirements. **HANYS urges CMS to provide hospitals with an opportunity to remedy technical or administrative deficiencies before denying an attestation.** A hospital should not lose payment because of a correctable documentation error, a discrepancy in CMS records or a delay in CMS completing its review when the hospital has submitted its attestation in a timely manner and is cooperating with CMS.

HANYS urges CMS to implement the provider-based requirements in a manner that minimizes duplicative administrative burden, provides reasonable flexibility for hospitals and avoids unintended payment disruptions for otherwise compliant PBDs.

Inpatient-only list

The inpatient-only list was established to identify procedures that, because of their invasive nature, the underlying condition of the Medicare beneficiary or the need for at least 24 hours of postoperative recovery and monitoring, are appropriately furnished and paid for in the inpatient hospital setting. While CMS has appropriately updated the IPO list over time to reflect advances in surgical techniques and

clinical practice, it has historically done so through a deliberate, evidence-based review of individual procedures. For CY 2027, however, CMS proposes to continue the second phase of a three-year elimination of the IPO list by removing an additional 637 procedures, with complete elimination of the list by CY 2028.

HANYS strongly opposes CMS' proposal to eliminate the IPO list in its entirety. The IPO list has long served as an important safeguard that recognizes not every procedure is appropriate for outpatient care for the Medicare population. Rather than continuing its longstanding process of evaluating individual procedures based on clinical evidence, utilization patterns and hospital readiness, CMS proposes to eliminate the remaining IPO list according to a predetermined timeline. Such an approach places administrative goals ahead of careful clinical review and does not adequately account for the complexity of the Medicare population. The appropriate setting for a procedure should be determined based on patient safety, clinical evidence and the capabilities needed to safely manage potential complications.

CMS' proposal raises several significant concerns:

- **Patient safety and clinical appropriateness.** Although surgical techniques and perioperative care continue to advance, many procedures remain clinically appropriate only in the inpatient setting for a substantial portion of Medicare beneficiaries. Older adults often have multiple chronic conditions, frailty, functional limitations or limited caregiver support that increase the need for postoperative monitoring, care coordination and timely management of complications. The IPO list remains an important safety safeguard because it recognizes that appropriate site of care depends not only on the technical feasibility of performing a procedure, but also on the patient's ability to recover safely after the procedure.

  Several of the procedures proposed for removal involve substantial clinical risk, including potential major blood loss, extensive invasion of body cavities or involvement of major blood vessels, and complications that may require immediate multidisciplinary intervention. For example, the proposed removals include repair of a ruptured spleen (HCPCS 38115), extensive liver resection (HCPCS 47122), pancreatectomies (HCPCS 48152–48155), total hysterectomy (HCPCS 58150), pelvic exenteration (HCPCS 45126) and repair of a ruptured uterus (HCPCS 58520). These procedures can involve significant blood loss, complex surgical dissection and a heightened risk of serious complications that may require rapid access to blood products, advanced imaging, specialty surgical backup, intensive care and the ability to return immediately to the operating room. These hospital-level resources are critical when complications arise and transferring a patient after a complication has occurred may introduce dangerous delays.

  CMS should not equate advances in surgical techniques or the availability of outpatient care for selected patients with demonstrating that these procedures are appropriate for all Medicare beneficiaries in an outpatient setting. The appropriate site of care must account for both the procedure and the individual patient's clinical risk, as well as the resources available to manage unexpected complications.

- **Lack of procedure-specific clinical review.** CMS previously removed procedures from the IPO list only after evaluating them individually against clinical criteria, including the nature of the procedure, expected need for postoperative monitoring, patient complexity and whether the procedure could be safely performed in the outpatient setting. The current proposal instead advances hundreds of procedures toward outpatient payment as part of a predetermined multi-

year phaseout, without demonstrating that each procedure proposed for removal is clinically appropriate for outpatient care for Medicare beneficiaries.

A procedure-by-procedure review is particularly important because clinical risk can vary based on the surgical approach, patient risk factors and facility capabilities. For example, procedures such as nephrectomy or colectomy may present substantially different risks depending on whether they are performed through an open or laparoscopic approach, the patient's comorbidities and the availability of appropriate postoperative care. CMS should not rely on broad procedural categories or physician judgment alone to support removal from the IPO list. Physician judgment is essential, but it should operate within clear patient-selection criteria and facility-capability safeguards established through transparent, procedure-specific review.

- **Payment adequacy.** Removal from the IPO list also has significant payment implications. CMS acknowledges that the continued elimination of the IPO list may require restructuring existing APCs or creating new APCs to ensure appropriate OPPS payment. CMS should resolve these payment issues before moving procedures to outpatient payment, rather than shifting procedures into the OPPS while the adequacy of payment remains uncertain. Inadequate payment could affect hospitals' ability to safely provide these complex services.

For these reasons, HANYS strongly urges CMS to withdraw its proposal to remove 637 procedures from the IPO list for CY 2027 and to abandon the planned elimination of the IPO list in CY 2028. While HANYS recognizes that advances in medicine may support removing certain procedures over time, a wholesale elimination of the IPO list is neither clinically justified nor operationally prudent. Maintaining the IPO list as an evidence-based safeguard better protects Medicare beneficiaries while preserving access to safe, high-quality inpatient surgical care.

Outlier threshold

CMS proposes to increase the outlier fixed-loss threshold from $6,225 to $7,100 for CY 2027 to maintain outlier payments at 1.0% of total OPPS payments — an increase of about 14%. CMS indicates that this proposal is based on CY 2025 claims, the most recent available data. **HANYS is concerned that an increase of this magnitude may materially reduce the effectiveness of the outlier policy and inappropriately deny reasonable outlier payments for hospitals treating exceptionally costly Medicare cases.**

Since CMS uses the same proposed charge inflation factor as under the Inpatient PPS, the increase is largely due to rapid charge inflation, including a 7.31% one-year increase in average covered charges per case and a resulting two-year compounded charge inflation factor of 15.15%. While HANYS appreciates CMS' efforts to maintain budget neutrality within the OPPS, we are concerned that reliance on recent charge growth produces an outlier threshold increase that far exceeds hospitals' ability to absorb uncompensated high-cost cases during a period of continued financial instability, elevated labor costs and increasing patient acuity.

To address and mitigate the proposed 14% outlier threshold increase, while still ensuring the appropriate outlier spend, **HANYS urges CMS to explore alternatives to the charge inflation factor driving the increase.** Specifically, for the final rule HANYS suggests that CMS explore using a multi-year rolling average for charge inflation calculations rather than relying heavily on a single year of charge growth data. Using a broader averaging methodology would help smooth unusual fluctuations in charges and produce a more stable and predictable outlier threshold from year to year. Alternatively, CMS could consider linking the charge inflation factor to the market basket or another more appropriate trend factor.

CMS' response to similar recommendations in the Inpatient PPS final rule underscores the need for the agency to evaluate these alternatives. CMS acknowledged the recommendations but stated that commenters had not provided evidence demonstrating that alternative approaches would more accurately predict the targeted outlier threshold. **HANYS believes this rationale should not preclude CMS from evaluating alternative methodologies under the OPPS.** CMS is uniquely positioned to model these approaches using its extensive claims data and determine whether they would produce a more stable and accurate threshold while maintaining the 1.0 percent outlier payment target.

Prior authorization

CMS proposes to expand the prior authorization program to additional botulinum toxin injection codes. HANYS recognizes that prior authorization can be an appropriate utilization-management tool when applied in a targeted manner. However, we are concerned that expanding prior authorization to additional botulinum toxin services could create unnecessary administrative burdens and delay medically necessary treatment for patients with serious neurological and other conditions. Delays in treatment can result in worsening symptoms, functional decline and other adverse consequences.

HANYS urges CMS not to finalize the proposed expansion without establishing robust safeguards to ensure that prior authorization does not become an inappropriate barrier to medically necessary care. At a minimum, CMS should establish clear clinical criteria, expedited review timelines for time-sensitive treatment, continuity-of-care protections and exemptions or streamlined processes for medically necessary services consistent with FDA-approved indications or widely accepted clinical guidelines. CMS also should avoid repeated authorization requirements when a patient's treatment plan and clinical circumstances remain unchanged.

Prior authorization should promote appropriate utilization, not impede timely access to clinically appropriate care. For these reasons, **HANYS urges CMS to address these concerns before expanding the program to include the remaining botulinum toxin injections.**

Request for information: Hospital price transparency

HANYS appreciates the opportunity to provide feedback on CMS' request for information regarding potential approaches to change the standardization and comparability of hospital price transparency data. HANYS supports efforts to make price transparency information more useful and meaningful for consumers and other stakeholders. Any future policy development should prioritize data quality, consistency and practical usability while minimizing unnecessary administrative complexity. Specifically, we recommend the following:

> **Complex contract provisions.** CMS seeks feedback on how outlier, stop-loss, rate-tiering, carve-out and other contract provisions should be standardized in the machine-readable file. HANYS recommends that CMS recognize that these provisions often apply at the contract or service-category level and can vary significantly based on negotiated arrangements. This variability makes it difficult to develop standardized data elements that accurately capture many of these provisions. Requiring hospitals to translate complex contractual terms into standardized data elements could result in incomplete, inaccurate or misleading information. CMS should therefore prioritize clear guidance and flexibility rather than prescriptive reporting requirements. In addition, CMS should protect confidential and proprietary information from public disclosure and avoid requirements that could compel hospitals to disclose competitively sensitive contract terms without imposing comparable requirements on insurers.

Payer and plan information. CMS seeks feedback on standardizing payer and plan names and identifiers. HANYS supports greater consistency but encourages CMS to rely on existing identifiers and information already available to hospitals wherever possible. Hospitals should not bear responsibility for resolving variations in payer and plan information that may originate with insurers. CMS should engage payers and other stakeholders in developing any standardized approach.

Consumer-friendly displays and shoppable services. HANYS encourages CMS to preserve hospitals' flexibility to use price estimator tools to meet consumer-friendly display requirements. These tools are often more useful to patients because they can provide individualized cost information and explain what is included in, or excluded from, a price, including related ancillary services. CMS should also carefully assess whether expanding the required list of "shoppable" services would meaningfully improve consumer decision-making. Some existing CMS-specified services may not be broadly applicable or useful to patients, and the list has not been updated since 2020. Rather than expanding the list, CMS should first evaluate whether the current services provide accurate, comparable and actionable information for patients without creating unnecessary administrative burden.

Lastly, HANYS encourages CMS to allow sufficient time to evaluate the substantial price transparency requirements implemented in 2026 before pursuing additional requirements. Any future changes should be carefully evaluated for their accuracy, usefulness and administrative impact, with adequate implementation time for hospitals and their vendors.

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

Sincerely,

Thomas J. Quatroche Jr., PhD
President and CEO