Kansas Hospital Association

August 31, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Submitted electronically via regulations.gov.

Dear Administrator Oz,

On behalf of our 124 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule for the Medicare Hospital Outpatient Prospective Payment System for calendar year (CY) 2027.

Kansas hospitals provide care across a geographically diverse state, often serving as both the health care safety net and an essential economic anchor for their communities. Hospital outpatient departments (HOPDs) are an increasingly important part of that mission, providing access to imaging, cancer treatment, infusion services, behavioral health care, surgery and other services for patients who frequently have greater clinical complexity than those treated in freestanding settings. Medicare policy should recognize the resources required to maintain that access and should not create new barriers to hospital-level outpatient care.

KHA supports several provisions in the proposed rule, including targeted efforts to reduce unnecessary quality-reporting burden, a more workable approach to validating outpatient quality data, and CMS' continued consideration of policies to strengthen domestic medical supply chains. However, we have significant concerns with proposals that would further reduce hospital reimbursement, expand site-neutral payment reductions, move complex procedures out of the inpatient setting without sufficient clinical safeguards, and impose additional prior authorization and administrative requirements.

Kansas Hospital ASSOCIATION

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

- Oppose CMS' proposal to reduce payment for imaging without contrast services furnished by off-campus excepted provider-based departments (PBDs) and urge the agency to withdraw it.
- Not finalize either the proposed acceleration of the 340B remedy clawback or the proposed reduction in reimbursement for 340B-acquired drugs to ASP minus 33.4%.
- Recommend that CMS return to its standard process from 2025 for removing procedures from the inpatient-only (IPO) list.
- Recommend that CMS withdraw its proposed expansion of prior authorization to apply to additional botulinum toxin injection codes, which would affect services that are predominately medical, not cosmetic.
- Urge CMS to abandon the proposed expansion of the ASC covered procedures list (CPL) due to safety concerns arising from the inappropriately weakened standard and general exclusion criteria for the ASC CPL.
- Urge CMS to help mitigate the increased burden that the statutory requirement for hospitals to obtain separate National Provider Identifiers (NPIs) for each of their off-campus PBDs would place on hospitals, physicians, payers and Medicare beneficiaries.

Outpatient PPS Payment Update

KHA remains concerned that CMS' proposed net 2.4% increase in OPPS payments for CY 2027 does not keep pace with the real-world cost growth hospitals continue to experience. The update reflects a projected 3.2% hospital market basket increase reduced by a 0.8 percentage point productivity adjustment. That reduction is especially difficult to reconcile with the persistent growth in hospital labor, pharmaceutical, supply and administrative expenses.

The financial pressures described in KHA's FY 2027 IPPS comments apply equally to outpatient care. Kansas hospitals average only 62 days cash on hand compared with a national average of 218 days, and Medicare payments to Kansas hospitals cover approximately 69% of the cost of caring for Medicare patients. Nationally, total hospital expenses increased 7.5% in 2025, including a 5.6% increase in workforce costs, a 9.9% increase in supply costs and a 13.6% increase in drug costs. Kansas hospitals also shoulder more than $1 billion in uncompensated care annually.

These pressures are compounded by administrative costs that are not reflected in Medicare payment updates. Hospitals devote significant staff and resources to prior authorization, claims denials and payment collection, particularly as Medicare Advantage enrollment grows. These expenses divert resources from patient care, workforce investments and new technologies while Medicare payment continues to fall further behind the cost of providing care.

KHA urges CMS to revisit the accuracy of its market basket forecasts and the cumulative effect of prior forecast errors. We also ask CMS to work with Congress to reduce the magnitude of the productivity adjustment or eliminate it. A productivity adjustment that assumes hospitals can continually achieve economy-wide productivity gains does not adequately account for the labor-intensive nature of hospital care, mandatory staffing needs, 24/7 readiness, increasing patient acuity and the investments necessary to improve quality and efficiency.

340B Drug Payment and OPPS Remedy Clawback

KHA strongly opposes two proposals that would impose substantial new reductions on hospitals participating in the 340B Drug Pricing Program: increasing the annual OPPS conversion-factor reduction associated with the 2018-2022 340B remedy from 0.5% to 3%, and paying certain 340B-acquired drugs at average sales price (ASP) minus 33.4%. These proposals would place new financial pressure on safety-net hospitals at the same time they are absorbing rising costs, increasing uncompensated care and major changes in federal coverage and Medicaid policy.

First, CMS should rescind the remedy clawback rather than accelerate it. KHA agrees with the American Hospital Association that CMS lacks statutory authority to recoup these funds through an across-the-board reduction to future OPPS payments. At a minimum, if CMS maintains the clawback, it should retain the existing 0.5% annual adjustment. Increasing the reduction to 3% would represent a six-fold increase in the annual recoupment and would disregard the reliance interests CMS itself recognized when it established the 16-year repayment period. Hospitals make multi-year budgets, capital plans and service-line decisions based on finalized Medicare policy. An abrupt acceleration would materially disrupt those plans and reduce resources available for patient care.

Second, CMS should not finalize its proposal to reimburse certain 340B-acquired drugs at ASP minus 33.4%. The Social Security Act permits CMS to vary drug reimbursement by hospital group only when it has conducted a valid acquisition-cost survey. The survey on which CMS relies does not meet that standard. CMS reports usable data from only 23.1% of 340B hospitals and 29.8% of hospitals overall before its sample refinements; even after refinement, the survey includes only 28.6% of 340B hospitals. That is not a sufficiently broad foundation for a sweeping payment reduction affecting 340B hospitals nationwide.

The statutory problem is not simply the overall response rate. The statute requires a large sample sufficient to produce a statistically significant estimate of average acquisition cost for each specified covered outpatient drug. CMS instead relies on an aggregate analysis. The proposed rule

does not demonstrate a statistically significant acquisition-cost estimate for each individual drug, and the survey excludes or aggregates data in ways that can obscure meaningful variation across oncology drugs, radiopharmaceuticals, rare-disease products and other therapies. KHA therefore agrees with AHA that the survey cannot support a hospital-group-specific payment reduction.

The policy rationale is also unclear. CMS proposes to implement the 340B drug reduction in a budget-neutral manner, meaning the reduction is not principally a Medicare savings policy. Instead, it would redistribute 340B savings away from 340B hospitals that use program savings to support services for vulnerable patients and communities. If CMS believes OPPS drug payment needs refinement, it should pursue a legally valid, drug-specific methodology based on representative data and should provide stakeholders the underlying information necessary to evaluate that methodology before making any payment reduction.

For these reasons, KHA urges CMS not to finalize ASP minus 33.4% for 340B-acquired drugs and not to accelerate the remedy clawback. If CMS nevertheless proceeds with any 340B payment change, it should ensure full annual budget neutrality, avoid reductions for drugs for which reliable drug-specific acquisition-cost data do not exist, and provide a meaningful transition period.

Site-Neutral Reduction in Payment for Imaging Without Contrast in Excepted Off-Campus PBDs

KHA opposes CMS' proposal to pay only 40% of the OPPS rate for imaging without contrast services furnished in excepted off-campus PBDs. Congress expressly grandfathered off-campus departments billing under the OPPS before Nov. 2, 2015. CMS has nevertheless expanded site-neutral reductions first to clinic visits, then to drug administration, and now proposes to extend those reductions to imaging without contrast. KHA urges CMS to withdraw this proposal.

The proposal rests on an overly simplistic comparison between hospital outpatient departments and independent physician offices. HOPDs disproportionately serve patients who are sicker, more clinically complex, disabled, dually eligible for Medicare and Medicaid, and more likely to live in rural communities. The same imaging code can require substantially different resources depending on a patient's cognitive status, mobility, comorbidities, need for monitoring and the availability of emergency support. Payment policy should account for those differences rather than assume that the service is interchangeable across settings.

CMS also has not adequately demonstrated that payment differentials are the cause of growth in HOPD imaging volume. Physician practices increasingly seek hospital affiliation because of declining physician reimbursement, workforce shortages, administrative burden and rising operating costs. In many Kansas communities, hospital ownership or support of outpatient services is what preserves local access when an independent practice can no longer remain viable. Reducing reimbursement after hospitals have stepped in to maintain services risks accelerating the very access problems CMS should be working to prevent.

The proposal is particularly concerning for rural communities. Although CMS proposes to continue exempting rural sole community hospitals, many rural and small community hospitals that play similar access roles do not hold SCH status. KHA urges CMS to consider the broader rural impact and the cumulative effect of successive site-neutral reductions. If CMS proceeds despite these concerns, the policy should be budget neutral and include broader protections for rural and safety-net hospitals.

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

In the proposed rule, CMS also seeks comment on other ways or other services to which it should expand its site-neutral payment reductions. For all the reasons discussed above, we are strongly opposed to *any* proposals to expand site-neutral payment cuts. To do so would fundamentally rewrite the law by using the described "method" to evade the outpatient PPS system. Specifically, the current Medicare outpatient PPS, as enacted by Congress, as well as its resulting payments (despite being substantially less than the cost of care), recognize that HOPDs are unique — they treat sicker, more complex patients from medically underserved populations, and they also follow more rigorous licensing, accreditation and regulatory requirements compared to other care settings.[1] Hospitals and health systems, including their HOPDs, need sufficient financial and operational resources to provide high acuity and emergency preparedness and response services that only they can provide. This includes maintaining 24/7 capacity to respond to natural and man-made disasters, public health emergencies and other unexpected traumatic events. It also means being available to care for all individuals experiencing an emergency, regardless of their ability to pay. Further site-neutral cuts may result in hospitals closing or reducing these vital services, reducing patient access in communities nationwide, particularly in rural and underserved areas.

Year Two of Eliminating the IPO List

CMS proposes to remove an additional 637 services from the IPO list in CY 2027 as part of the three-year phase-out finalized last year. KHA supports appropriate movement of procedures to outpatient settings when supported by clinical evidence and patient safety. We remain concerned, however, that a predetermined timeline for eliminating the IPO list places the schedule ahead of the clinical evidence.

The IPO list serves an important patient-safety function by identifying procedures that, because of their invasiveness, expected recovery needs or risk of complications, are generally appropriate for inpatient care. Removal from the IPO list does not merely create flexibility; it can create pressure from utilization management policies and payers to perform procedures in outpatient settings even when inpatient care is clinically appropriate for an individual patient.

[1] AHA. (March 11, 2026) "The Cost of Caring: Challenges Facing America's Hospitals as They Care for Patients in 2026." https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

KHA urges CMS to return to the more deliberate process used before the wholesale phase-out, under which procedures were evaluated individually based on clinical evidence, stakeholder input, expected length of stay, complication risk and whether the procedure was commonly and safely performed on an outpatient basis. CMS should retain procedures for which the evidence is insufficient and should not treat technological advances for carefully selected patients as proof that a procedure is appropriate for the broader Medicare population.

For procedures removed from the IPO list, CMS should preserve physician judgment, maintain protections against inappropriate denials of inpatient admissions, monitor beneficiary outcomes and provide adequate transition time. CMS should also ensure that removal from the IPO list is not treated as an automatic basis for adding the same procedure to the ASC covered procedures list.

Diagnostic Radiopharmaceutical Payment

KHA supports moving from Mean Unit Cost (MUC) to Average Sales Price (ASP) for separately payable advanced diagnostic radiopharmaceuticals beginning in CY 2027. From a hospital finance perspective, reimbursement should more closely reflect what hospitals are actually paying for these products. ASP is a methodology already familiar under the OPPS and is more closely tied to market pricing, providing a more predictable and sustainable payment approach for hospitals that furnish advanced diagnostic imaging services.

This policy is particularly important because diagnostic radiopharmaceuticals support imaging used to diagnose and manage serious conditions, including breast and prostate cancer, neurological disease, and cardiac disease. Hospitals need a reimbursement methodology that supports continued access to these services without creating unnecessary financial uncertainty.

To make an ASP-based approach workable, CMS should issue updated guidance on ASP reporting by the end of CY 2026 and establish clear reporting requirements. Without timely and consistent ASP reporting, hospitals may continue to face uncertainty regarding appropriate payment. KHA therefore urges CMS to provide the necessary reporting guidance and use ASP to establish separate payment for advanced diagnostic radiopharmaceuticals in CY 2027.

Expansion of Botulinum Toxin Injection Codes for HOPD Prior Authorization Process

KHA urges CMS to withdraw its proposal to add eight botulinum toxin injection codes to the HOPD prior authorization program beginning July 1, 2027. The affected procedures are predominantly medical rather than cosmetic and are used to treat significant neurologic, neuromuscular, salivary, voice and spasticity-related conditions. Patients often receive these injections as part of an established, recurring treatment plan, and delays can result in worsening pain, muscle spasm, impaired mobility, speech problems, excessive salivation and swallowing or aspiration concerns.

CMS cites utilization growth as a principal justification for prior authorization, but utilization growth alone does not establish inappropriate care. Expanded FDA-approved indications, greater

use in rehabilitation and movement-disorder care, and rebound from pandemic-era care delays are all plausible explanations. CMS has not presented diagnosis-level utilization, specialty trends, denial data or other evidence sufficient to show that these services are broadly unnecessary.

If CMS nevertheless proceeds, KHA urges the agency to narrowly target demonstrated areas of inappropriate utilization and establish strong continuity-of-care protections. These should include streamlined renewals for patients with a documented prior response, authorization periods aligned with clinically appropriate repeat-treatment intervals, exemptions for established courses of therapy, clear urgent-review standards, transparent medical-necessity criteria, and ongoing monitoring of denials, appeals, treatment delays and beneficiary complaints.

Provider-Based Status: Separate NPIs and Attestation Requirements for Off-Campus PBDs

KHA recognizes that CMS is implementing Section 6225 of the Consolidated Appropriations Act, 2026, which will require off-campus outpatient departments to bill under separate National Provider Identifiers (NPIs) and satisfy new attestation requirements beginning in 2028. We appreciate CMS' efforts to reduce burden in the proposed implementation. Nevertheless, the operational implications are substantial for hospitals, Medicare contractors, physicians, other payers and patients.

CMS should require only the initial attestation and one subsequent attestation contemplated by the statute, with the subsequent attestation due within five years. Hospitals with multiple off-campus departments should be permitted to stagger attestations within that period. CMS also should permit electronic signatures and allow an authorized submitter to file attestations on behalf of a hospital's authorized official.

The separate-NPI requirement creates significant claims-processing risks. A new department NPI can break links in payer systems, coordination-of-benefits workflows, professional claims and existing prior authorizations. KHA urges CMS to provide at least a 12-month enforcement-discretion period, establish a standardized crosswalk linking each off-campus department NPI to the hospital's main-campus NPI, conduct end-to-end testing with Medicare contractors and secondary payers, and issue clear instructions for resolving NPI mismatches without forcing hospitals or patients into appeals.

CMS also should require Medicare Advantage and other CMS-regulated plans to recognize existing prior authorizations across affiliated hospital and department NPIs when the service, ordering provider and course of treatment have not changed. A beneficiary should not lose an authorization solely because a federal billing requirement caused the hospital to obtain a new NPI. For multi-office off-campus locations, CMS should allow hospitals the operational flexibility to obtain a single NPI and submit a single attestation for the location where appropriate.

Payment for Software as a Medical Service

KHA directionally supports CMS' proposal to establish an interim payment approach for Software as a Medical Service (SaMS) while the agency develops a longer-term methodology, and we support maintaining existing payment assignments during the transition. Hospitals increasingly rely on software-based clinical technologies, including artificial intelligence-enabled tools, and payment policy must evolve with those technologies without disrupting beneficiary access.

CMS should clarify whether the change from Software as a Service to SaMS is purely terminology or signals a broader change in scope, classification or payment. The agency also should explain how it will distinguish clinical SaMS from hybrid platforms that include both clinical and administrative functions.

As CMS develops a permanent methodology, payment should reflect the full cost of acquiring, integrating, validating, maintaining and securing these technologies. Licensing fees are only one component. Hospitals also incur costs for infrastructure, interoperability, workforce training, clinician time to validate outputs, software updates, vendor oversight, cybersecurity monitoring and risk management. KHA also cautions against increasing payment for emerging technology solely by reducing payment for unrelated hospital services through budget neutrality.

Hospital Outpatient Quality Reporting Program

KHA supports CMS' proposal to remove the Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period. The measure primarily assesses documentation rather than whether appropriate clinical care occurred. Removing low-value measures allows hospitals to focus limited quality-improvement resources on measures that are actionable and meaningful to patients.

KHA also supports CMS' proposed updates to OQR data validation, including incorporating electronic clinical quality measures into the existing validation framework with separate scoring and shifting from a 450-hospital random sample plus 50 targeted hospitals to a smaller random sample with more targeted validation. We also support eliminating duplicative resubmission of records already submitted electronically during reconsideration.

CMS also seeks feedback on potential future use of an Advance Care Planning eCQM in the outpatient setting. KHA agrees that advance care planning is important but urges caution. The measure was designed for inpatient care, has not yet completed consensus-based entity endorsement, and may be difficult to implement consistently across EHR platforms. If CMS continues to consider the measure for OQR, it should narrow the denominator to outpatient encounters that represent sufficiently comprehensive care, avoid duplicative documentation across inpatient and outpatient settings, and complete consensus-based entity review before adoption.

Accrediting Organization Enforcement of EMTALA Administrative Requirements

KHA supports CMS' proposal to allow accrediting organizations to assess compliance with specified EMTALA administrative and documentation requirements. These requirements are well suited to the records-based reviews already performed during accreditation surveys, and alignment could reduce duplicative and operationally disruptive oversight.

CMS should establish a clear transition timeline, allowing accrediting organizations sufficient time to update survey procedures and train surveyors. We also strongly request that CMS, accrediting organizations and the Office of Inspector General provide clearer guidance on hospital signage addressing threats and violence against health care workers. Hospitals need to be able to communicate that violence is unacceptable without creating uncertainty about EMTALA compliance. Written guardrails and examples of permissible signage would promote consistency and support safer care environments.

Request for Information: Strengthening the Standardization and Comparability of Hospital Price Transparency Data

KHA supports meaningful price transparency that helps patients understand their expected financial responsibility. Kansas hospitals have invested significant resources in machine-readable files, consumer-facing estimator tools and other compliance infrastructure. As CMS considers additional changes, the agency should focus on whether new requirements will make information more useful to patients rather than simply adding more data elements and administrative complexity.

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

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

Meaningful price transparency also requires consumer education and shared responsibility across stakeholders. Hospitals are working to make financial information easier to find and understand,

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

Increasing Transparency of Outlier Provisions and Additional Contract

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

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

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

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

2. *How are hospitals currently reporting contract terms for outlier payments, stop-loss, rate-tiering, carve-outs or other adjustments in the MRFs? Are the current formats sufficient for conveying these and other important contract terms? If not, what changes*

to the current formats, such as separate data elements, would be advised to accommodate the disclosure of such contract terms in a standard manner?

Hospitals report payer-specific negotiated charge information in accordance with CMS requirements and sub-regulatory guidance. However, the current standardized MRF format is not well-suited to conveying the full scope of complex hospital-payer contract terms. Hospital contracts with health plans are often lengthy and highly individualized and may incorporate multiple payment methodologies, service-specific provisions, payer policies, manuals, coding rules and administrative processes. These arrangements cannot be distilled neatly into a small set of standardized spreadsheet fields without losing critical context or creating misleading impressions.

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

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

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

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

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

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

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

<u>Standardization to Enhance Utility of the MRF</u>

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

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

Before imposing new requirements on free text fields, CMS should more clearly identify the use case for this information and determine whether the information can be obtained through a

less burdensome source. For example, if the goal is to understand payment amounts, data elements derived using historic allowed amounts are more useful than additional contract narrative. CMS should avoid requiring hospitals to shoehorn complex contract language into additional standardized data elements absent a clearly defined use case, as doing so would create substantial burden and may generate data that is less accurate because it lacks the context necessary to understand how the terms apply.

2. *Should CMS require more structured reporting of payer, plan, product, network, and employer (as applicable) information across hospital MRFs, and if so, which elements should be required? Are there existing identifiers for payers and plans, to which hospitals have access, that should be incorporated in the MRF?*

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

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

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

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

For the MRF, the most useful next step is not to add additional information in the files but to move toward greater stability. Hospitals, vendors and end users need time to implement recent changes, gain experience with the data, and determine what is working and what, if any, gaps

remain. Continual changes increase cost and reduce usability because every modification requires stakeholders to update files, systems, validation tools, analytic approaches and compliance processes. In addition, CMS should be aware that adding additional data fields will result in larger file sizes, which will further reduce usability of the data. Additional work is needed to ensure that any further changes to the file structure only add information that will enhance utility rather diminish usability.

Consumer-Friendly Display Request for Comment

1. *Should we revisit the number and types of CMS-specified shoppable services? What are the advantages and disadvantages of increasing or decreasing the number of shoppable services? Are there specific shoppable services that CMS should include, exclude, or update on the list of 70 CMS-specified items and services?*

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

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

2. *What would be the advantages and/or disadvantages of requiring hospitals to submit a shoppable services file? Alternatively, what would be the advantages and/or disadvantages of removing the deemed compliance for the price estimator tools? Does the current incongruity in how hospitals display shoppable services, with some posting a shoppable services file and others utilizing a price estimator tool, make it more difficult for consumers to actually compare prices for shoppable services across different*

hospitals? What positive or negative effects would consumers experience if the price estimator tool alone were no longer considered compliant?

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

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

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

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

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

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

It would be extremely difficult, and in some cases impossible, to create a static flat file containing the underlying data used by a price estimator tool. These tools often rely on dynamic information that changes regularly, including updated charge information, payer contract data,

benefit information, deductible status, prior utilization and historical claims patterns. A static file would become outdated quickly and could be misleading.

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

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

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

Yes, there are circumstances in which information displayed through a price estimator tool or shoppable services display may not match the hospital MRF. These differences can arise because the tools are designed for different purposes and operate at different levels of granularity.

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

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

5, 6 & 7. *Which data elements are important for consumers to make comparisons between hospitals? Would a standard shoppable services file template make the*

information more comparable? How could a shoppable services file indicate the ancillary services that are included in or excluded from the price? How should hospitals present ancillary items, implants, and bundled services so consumers better understand total expected costs? What approaches most effectively distinguish included versus excluded services? What additional information should we consider to enhance the comparability of the consumer-friendly display data between hospitals?

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

More broadly, CMS should avoid creating duplicate or conflicting requirements across hospital and health plan tools. The goal should be a coordinated ecosystem in which each policy plays a clear role: Hospital price estimator tools provide facility-specific estimates; health plan tools support cross-provider comparison; and uninsured/self-pay good faith estimates and AEOBs provide patient-specific estimates for scheduled care. This coordinated approach would better advance meaningful price transparency than additional changes focused solely on the hospital requirements.

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

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

Consideration of Potential Approaches for Separate Inpatient PPS Payment for Domestic Procurement of Personal Protective Equipment and Essential Medicines

Kansas Hospital ASSOCIATION

KHA appreciates CMS' continued consideration of separate payment to support a more resilient domestic supply chain for personal protective equipment and essential medicines. Hospitals experienced significant supply disruptions during the pandemic and continue to face vulnerabilities in drugs and medical supplies that are heavily dependent on foreign manufacturing.

KHA supports expanding eligible domestic PPE beyond respirators to include commonly used products such as nitrile gloves, gowns, syringes and needles. We also support a definition of domestic production that is consistent with the Make PPE in America Act. For essential medicines, CMS should consider a sufficiently broad set of critical products and supply-chain partners to meaningfully improve resilience, including appropriate products manufactured in allied OECD countries where necessary.

KHA strongly supports creation of a public CMS file identifying products that meet the applicable domestic criteria and their estimated domestic cost differentials. Hospitals generally do not have reliable visibility into manufacturers' full supply chains, and the burden of determining domestic status should not be placed on individual providers. Any reporting approach should minimize hospital burden and rely, where possible, on manufacturer attestations and automated claims processing.

Kansas hospitals are committed to improving quality, affordability and access for Medicare beneficiaries. Achieving those goals requires payment policies that reflect the cost and complexity of hospital care and regulatory policies that direct resources toward patients rather than unnecessary administrative work. We respectfully urge CMS to revise the CY 2027 OPPS final rule consistent with the recommendations above.

Thank you for the opportunity to comment and for considering the perspective of Kansas hospitals. If you would like additional information, please contact Shannan Flach at sflach@kha-net.org or Jaron Caffrey at jcaffrey@kha-net.org.

Sincerely,

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