***VIA ELECTRONIC SUBMISSION***

September 15, 2025

The Honorable Dr. Mehmet Oz
Center for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010

**Re: Proposed Rule on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency (File Code: CMS-1834-P).**

Dear Administrator Oz:

The Peterson Center on Healthcare ("the Center") appreciates the opportunity to submit comments on select provisions of CMS' CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems proposed rule.

The Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. We are working to create a more efficient and cost-effective healthcare system in the United States by finding and promoting innovative solutions that improve quality and lower costs. To advance these goals, we have prioritized efforts to improve data transparency, stimulate competitive healthcare markets, and promote the use of high-value health technology.

We believe that price transparency is foundational to competitive markets, smart policies, and accessible, quality care. Through our partnerships and grants, the Center is helping equip employers and other purchasers with the pricing data they need to be more effective managers of healthcare benefits for their employees or plan members. Recent actions by Congress and the previous and current administrations have been important in revealing how rising provider prices drive healthcare spending. Yet, our work at the Center underscores how much potential still exists to make price transparency data meaningful and actionable to improve healthcare outcomes and efficiency. We appreciate the opportunity to share insights and learnings from our work across price transparency and payment policy. Our enclosed comments largely focus on *"Section XIX: Updates to the Requirements for Making Public Hospital Standard Charges at 45 CFR 180.50,"* pertaining to the Hospital Price Transparency rules. In

addition, we offer comments on site-neutral payments (*Section X*) and Medicare Advantage data transparency to inform a market-based approach to establishing Medicare payment (*Section XX*).

**Summary Comments on the Proposed Rule**

- **The Center supports the enhancements the administration proposes to the hospital price transparency (HPT) machine readable file (MRF) reporting schema and the continued emphasis on compliance.** The proposed rule addresses an important set of technical standardization issues that will, in combination with CMS's May 22, 2025, guidance document,[1] make hospital price transparency data more usable.
- **We encourage CMS to push further in the final rule and via sub-regulatory guidance to put forward additional schema specifications and standardization requirements.** Doing so will improve HPT MRFs for use by researchers, policymakers, and purchasers to make price comparisons within and across markets. Further standardization may benefit hospitals by reducing complexity and also make compliance issues easier to spot compared to today, where variations in reporting conventions even by "compliant" hospitals continue to foster potentially inaccurate or misleading conclusions about true hospital prices.
- **The Center has called for the reporting of quantities in price transparency files for several years now, and we are pleased to see this proposed regulation move toward implementing this recommendation so that MRF users can know which hospital rates included in the MRF are meaningful and which are not.** Hospitals often have several dozen rates per diagnosis-related group (DRG), which is the classification system used to categorize patients with similar diagnoses and to pay hospitals according to that DRG. These rates per DRG can vary significantly. However, some rates are associated with insurance plans with very few enrollees and therefore should not be regarded as meaningful data points. Without quantities, it is difficult to determine

[1]CMS took expedited actions in 2025 to address some of the more problematic and oft-recognized shortcomings with the data. Via its May 22 guidance document, and now with this Proposed Rule, CMS requires hospitals to:

- Display payer-specific standard charges as dollar amounts in their machine-readable files (MRFs) whenever calculable;
- Discontinue encoding nine 9s and encode actual dollar amounts in the estimated allowed amount within the MRF; and
- Use electronic remittance advice data from the previous 12 months to calculate the "estimated allowed amount."

Updated Hospital Price Transparency Guidance Implementing the President's Executive Order "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information." Center for Medicare and Medicaid Services. May 22, 2025. https://petersonhealthcare.org/wp-content/uploads/sites/7/2025/06/PetersonCenterHealthcareCMSRFIHealthTech.pdf

which of the dozens of rates per DRG per hospital represent meaningful reimbursement amounts. **Therefore, we support the proposed additional technical requirements on reporting of allowed amounts, and we recommend that CMS go further to include counts of all services provided in the data.** For estimated allowed amounts associated with an algorithm or percentage of charge rates, the proposed clarification requiring median, 10th, and 90th percentile allowed amounts and counts of allowed amounts will allow MRF users to understand the frequencies that those estimated allowed amounts are used by providers. However, items and services in MRFs that are not paid algorithmically or as a percentage of charge would also benefit from specifying the quantity of patient utilization for reasons we detail in our comments. Thus, we recommend that CMS create an additional schema element called "count_services" for all services with a reported negotiated rate that includes the count of times that service has been paid for in the 12-month period prior to HPT MRF release.

- **Applying site-neutral payments to additional outpatient services, specifically drug administration services, is a valuable way to reduce Medicare spending without compromising quality** by helping to address existing incentives for providers to shift care towards higher-paid facilities**.**
- **The Center supports CMS' proposal to require hospitals to report the median payer-specific negotiated charges with Medicare Advantage Organizations (MAOs) on the Medicare cost reports.** If finalized, this information will help to fill a critical gap in price transparency data on the value of Medicare Advantage and represents a meaningful step towards developing an alternative approach to determining Medicare payment that does not rely on the highly inflated hospital chargemaster rates.

The Center shares CMS's commitment to improving price transparency, data usability, and efficiency of the Medicare program and we appreciate the opportunity to contribute to this important work. For any questions or follow-up, please contact Natalie Joyce, Vice President of Advocacy at njoyce@petersonsolutions.org.

Sincerely,

Caroline Pearson
Executive Director
Peterson Center on Healthcare

## Proposal to Modify the Requirements for Making Public Hospital Standard Charges at 45 CFR 180.50

The Center strongly supported the provisions of CMS's May 22, 2025 updated guidance requiring hospitals to display payer-specific standard charges as dollar amounts in their HPT MRFs whenever calculable, discontinue encoding nine 9s and encode actual dollar amounts in the estimated allowed amount within the MRF, and use electronic remittance advice data from the previous 12 months to calculate the "estimated allowed amount."[2]

These policy advancements take important steps toward improving the accuracy and completeness of HPT MRF data, which enhances its utility for market participants and policymakers alike.

### *Proposal to Add the 10th and 90th Percentile Allowed Amounts and Count of Allowed Amounts*

In this proposed rule, CMS puts forth a revision to § 180.50(b)(2)(ii)(C) to require hospitals to calculate and encode the 10$^{th}$ percentile, median (50$^{th}$ percentile), and 90$^{th}$ percentile allowed amounts in dollars when the payer-specific negotiated charge is based on a percentage or algorithm, a proposal that pushes further toward improving accuracy and completeness of the MRF data.

**The Center appreciates these proposed changes as they will enhance data utility for researchers, innovators, purchasers (including their brokers and consultants) and, patients seeking to understand price variation across hospitals and payers in a market.**

**The Center also supports the CMS proposal requiring the reporting of the *count* of allowed amounts when a price is based on a percentage or an algorithm.** Median allowed amounts, and 10$^{th}$ and 90$^{th}$ percentile amounts need to be interpreted in the context of the number of cases (or quantities) for which each procedure is performed.

**CMS should also require hospitals to provide the number of cases (e.g., the number of services/procedures performed, items supplied during the reporting period) for codes and procedures that are paid set amounts (i.e. not by percentage or algorithm).** In practice in the context of the MRF, this means CMS will now require a count of how often each row in the MRF data gets paid. CMS can accomplish this by adding a field called "count_services" that includes the count of times that service has been paid for by a payer in the 12-month period prior to the data being

[2] Response to CMS Hospital Price Transparency Accuracy and Completeness Request for Information. Peterson Center on Healthcare. July 21, 2025. https://petersonhealthcare.org/news/center-responds-to-rfi-on-hospital-price-transparency/

released. This would make quantities available for all services, including many with rates not paid by percent of charge or algorithm. Adding quantity information is critical to:

- Help distinguish between frequently performed and rarely performed services;
- Estimate financial impact based on potential changes in rates;
- Help direct patients to locations that regularly perform procedures, as higher volume providers generally have higher quality;
- Help identify outliers and/or anomalies and their relative importance;
- Prioritize higher-volume cases for auditing and evaluation; and
- Better understand real-world impact of prices on patients.

### *Additional opportunities to standardize the HPT schema*

Work with our grantees PBGH and Peterson-KFF Health System Tracker provides examples of both the challenges with and the incredible potential of HPT and health plan (TiC) MRF data.[3,4] In many cases, HPT and TiC MRF data is incomplete, entirely missing, and—when available—unreliable. Yet, when the data is usable, it reveals the vast differences in prices for procedures within a single hospital, within a region or state, across payers, and even across networks from the same parent payer. Our work with the MRFs highlights the opportunity for CMS to advance policies that overcome these data challenges and make the MRFs easier to use for reliable price comparisons.

Several HPT data challenges limit the ability of MRF data users to draw comparisons across hospitals in a market or assess the reasonableness of prices—analyses that are critical to the fiduciary obligations of employers and their purchasing partners.

1. Lack of specificity: It is often unclear how listed prices correspond to services, especially for episodes of care (e.g., negotiated rates attached to a treatment

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[3] PBGH Launches Groundbreaking Health Care Data Project, Tackling Data Transparency Challenges and Strengthening Employer Fiduciary Compliance. January 29, 2025. https://www.pbgh.org/pbgh-launches-groundbreaking-health-care-data-project-tackling-data-transparency-challenges-and-strengthening-employer-fiduciary-compliance/
Creating a Data Framework by Combining Health Care Cost Transparency and Quality Data for Purchasers. Purchaser Business Group on Health. August 2025. https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

[4] Lo J, Claxton G, Wager E, Cox C, Amin K. Ongoing challenges with hospital price transparency. *Peterson-KFF Health System Tracker*. February 10, 2023. https://www.healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/
Kurani N, Ramirez G, Hudman J, Cox C, Kamal R. Early results from federal price transparency rule show difficulty in estimating the cost of care. *Peterson-KFF Health System Tracker*. April 9, 2021. https://www.healthsystemtracker.org/brief/early-results-from-federal-price-transparency-rule-show-difficultly-in-estimating-the-cost-of-care/
Claxton G, Cotter L, Rakshit S. Challenges with effective price transparency analyses. *Peterson-KFF Health System Tracker.* February 25, 2025. https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/

episode for a hip replacement might correspond to a per diem charge instead of the entire episode).

2. Missing data: Contextual pieces of information for interpreting the applicability of price are missing, such as carrier contract type and market served (for example, Medicare Advantage, Medicaid, and commercial), as prices and payment rates typically vary across markets.
3. Data quality: Data quality varies widely, with many files including implausibly low or high values for negotiated rates (e.g., negotiated rates representing a proportion or multiplier of a rate may appear as less than one dollar).
4. Poor compliance: A 2024 report by the HHS Office of Inspector General estimated that 46 percent of 5,879 hospitals in the U.S. were not compliant with hospital price transparency rules.[5] At the end of 2024, Patient Rights Advocate found that only 21.1% percent of the nation's 2,000 largest hospital systems were fully compliant with the hospital transparency rule.[6] CMS has initiated more than 2,500 enforcement activities against hospitals to review their compliance and levied civil monetary penalties for non-compliance against 10 hospitals so far in 2025.[7,8]

**To address these challenges, we urge CMS to consider requiring additional standardization measures and clarifying data elements, including:**

- Make the billing class (professional or facility) a mandatory, not optional, field;
- Standardize all HPT MRF fields to match TiC MRF schema, including updating the "code type" to "billing_code_type;"
- Require the hospital to identify the markets (e.g. Medicare Advantage, Medicaid, Marketplace, Commercial) associated with plans in their MRF. A new requirement to identify markets served should, where possible, seek to leverage identifiers such as those acquired by plans via CMS' Health Insurance Oversight System (HIOS);
- Require clearer delineation between base rates that are (a) code-specific but adjusted for patient characteristics or case severity; and (b) rates that are a constant amount where the DRG rate contains an adjustment for the diagnosis (these are not mutually exclusive);

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[5] Not All Selected Hospitals Complied With the Hospital Price Transparency Rule. Department of Health and Human Services Office of the Inspector General. November 2024. https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf

[6] Seventh Semi-Annual Hospital Price Transparency Report. Patient Rights Advocate. November 2024. https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024

[7] Hospital Price Transparency Enforcement Activities and Outcomes. Centers for Medicare and Medicaid Services. 2025. https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes/data

[8] Enforcement Actions. Centers for Medicare and Medicaid Services. June 26, 2025. https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions

- Clarify for hospitals through FAQs or examples how to consistently report per diem rates that vary over the period of stay;
- Clarify what belongs in the notes column and what is an algorithm because the latter triggers an estimated allowed amount calculation and the former does not; and
- Suggest standardized language or labels for use in notes column and standard algorithms for common rate structures (e.g. a case rate up to a day limit, with per diems afterward is common, but currently reported in multiple ways across multiple fields and the notes column). Standardizing the language here would minimize free text use by hospitals in the notes column and ease MRF user review burden.
- For items and services with rates that are paid as part of a bundle or episode of care within a claim, modify the schema to add a primary flag indicating which code type takes precedence for billing. Otherwise, require that rates only be associated with a code if they are the full payment amount.
    - This is intended to address where multiple billing codes can roll up to a single code, similar to how Addendum B in the OPPS maps HCPCS codes to APC codes.
- For episodes of care that span multiple visits and across a series of claims, CMS should work with experts to design a schema solution to flag these scenarios in the MRF.

*Calculation of Allowed Amounts*

CMS is proposing to require hospitals, beginning January 1, 2026, to use only EDI 835 ERA transaction data for calculating allowed amounts and counts of allowed amounts for services paid by algorithm or percentage of charge. CMS seeks comment on this proposal, whether there are instances where a hospital would not have access to EDI 835 ERA transaction data, and whether there are alternative data sources CMS should consider requiring hospitals to use to calculate the allowed amounts and count of allowed amount.

**The Center believes that establishing consistency in both data source and methodology will enhance comparability across hospitals and improve the utility of MRFs.** This standardized approach will help eliminate variations that currently exist due to different data sources and calculation methods. Therefore, we appreciate the proposal to leverage EDI 835 ERA transaction data to calculate these newly required data elements of the HPT MRF schema.

**EDI 835 ERA transaction data are the superior option for calculating allowed amounts and counts of allowed amounts, and we recommend that CMS work with industry stakeholders to address any access barriers** rather than compromise data

quality by permitting less reliable alternatives. From our work, we understand there are select instances where hospitals do not have access to EDI 835 ERA transaction data, including:

- *Registration Requirements*: Access to EDI 835 ERA transaction data depends on whether a hospital chooses to receive ERA transaction data and is actively registered with a clearinghouse or payer for electronic remittance and has the necessary software infrastructure to process 835 files.
- *Vendor Dependencies*: Many hospitals rely on third-party vendors to manage 835 file processing and may not have direct access to this data themselves. These hospitals would need to coordinate with their vendors to ensure proper access and data retrieval capabilities.

Despite these challenges, we believe the alternative of paper remittance advice and manual reconciliation is neither as efficient nor as reliable as EDI 835 ERA transaction data.

**We also recommend, as CMS proposes, requiring hospitals to report the actual number of adjudicated claims corresponding to the services** rather than using standardized ranges. Since hospitals must determine the precise count of allowed amounts to calculate the median, 10th percentile, and 90th percentile values, reporting the exact number is more efficient and precise. This approach:

- Eliminates the additional step of matching actual counts to predetermined ranges;
- Provides more precise information for MRF users; and
- Maintains flexibility for users who may wish to group data into ranges for analytical purposes using the exact values.

The actual count provides superior data granularity while still allowing for range-based analysis when desired by end users. We further recommend, as stated earlier in this comment letter, that CMS require hospitals to provide the number of cases for all services with a reported negotiated rate by payer and plan using a “count_services” element. Importantly, including the count of times that all services in a MRF have been paid will ensure a comprehensive understanding of patient utilization beyond those that are paid algorithmically or at a percent of charge.

**The Center also supports the 12-month lookback period requirement** as it provides sufficient data for understanding changes in prices while maintaining relevance to current pricing. However, we recommend CMS consider several important specifications regarding implementation of that requirement, as described below.

*a. Address Distinctions between Transaction Date vs. Date of Service*

Since the effective rate depends on a claim's date of service rather than EDI 835 ERA transaction dates, the proposed rule should explicitly specify that allowed amounts for rates posted in the MRF should only be calculated using claims with dates of service during which the posted rate was effective, regardless of when the claim was processed or the transaction occurred.

We suggest clarifying the requirement to calculate the allowed amounts using all EDI 835 ERA transaction data within a 12-month time period for claims that have a date of service when the posted rate was in effect.

This approach would:

- Prevent inclusion of reprocessed claims or claims with older dates of service that were subject to different rate structures;
- Vary appropriately by payer based on individual contract effective dates; and
- Include data from the full 12-months from relevant claims if the rate was effective for the entire period, or only use relevant data if the rate was effective for a shorter period (e.g., 3 months).

Without this clarification, the current language could permit hospitals to include any claim transaction that occurred while a rate was effective, even if the service was provided under a different rate structure. This would significantly compromise the accuracy of calculated allowed amounts.

*b. Considerations Regarding Implementation Timing*

Since hospitals are required to post one MRF once per year, in cases where a hospital has no historical claim remittance history at the time of posting, these rates could never receive a count/allowed amount before expiring. While nothing would preclude a hospital from updating its MRF when it has one or more remittances for an item or service, they are not required nor likely inclined to do so. More frequent (6 month) MRF updates might prevent such data gaps.

### *Proposal to Report Hospital National Provider Identifier (NPI) Information in the Machine-Readable File*

Beginning January 1, 2026, CMS proposes to require that reporting entities encode any national provider identifiers (Type 2 NPIs) with a primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit), and that is active as of the date of the most recent update, to the standard charge information in their MRFs. CMS is requesting comment on this proposal and any additional taxonomy codes that would be necessary or helpful to consider.

**The Center believes this proposal will facilitate MRF users' abilities to use HPT data, TiC data, and claims data to cross-validate those data sources and resolve**

**data inconsistencies among them.** We recommend including all NPIs associated with the hospital beyond these taxonomies as well. If implemented, the proposal should also allow users to link MRFs to hospital quality data sets made available by CMS.

We believe hospitals should also include the tax identification number (TIN) or employer identification number (EIN) that is applicable for each negotiated rate to assist with transparency data cross-referencing. This would prevent misattribution in cases where there are different rates for different parts of the hospital, such as one rate for an on-campus outpatient visit, and a different rate for an off-campus outpatient visit.

### *Proposal to Improve and Enhance Enforcement*

CMS is proposing a number of reforms designed to enhance compliance with price transparency rules that: a) Rescind existing requirements that a hospital make a "good faith effort" to ensure their MRF data are true, accurate, and complete, and instead require hospitals to attest that the MRF data are accurate and complete and have been reviewed by senior officials of the hospital; b) require hospitals to list the names of executives responsible for the accuracy and completeness of the data in the MRFs (but does not require a personal attestation by those officials); and c) reduce the amount of civil monetary penalty for noncompliance with the HPT requirements by 35 percent when a hospital agrees with CMS' determination of their noncompliance and waives the right to a hearing by an Administrative Law Judge.

The HHS Office of Inspector General issued a report in November 2024 estimating that nearly half of the 5,879 hospitals required to comply with the HPT rule did not comply with the requirements to make information on their standard charges available to the public.[9]

Despite CMS raising the penalties associated with noncompliance, there are still many hospitals that appear to be making an economic calculation of the monetary and reputational costs of compliance against the probability and consequences of federal enforcement.

Responding in part to the OIG report, CMS has levied penalties against 10 hospitals so far in 2025. However, the penalty amounts account for, at most, slightly more than one percent and, on average, less than one half of one percent of each hospital's annual hospital revenues. Still, several hospitals are appealing the penalties.

**The Center believes that CMS should impose stiffer and more immediate penalties on non-compliant hospitals,** including alternatives to civil monetary penalties—up to and possibly including de-certification under Medicare. CMS can also

[9] Not All Selected Hospitals Complied With the Hospital Price Transparency Rule. Department of Health and Human Services Office of the Inspector General. November 2024. https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf

motivate hospital compliance by exposing hospitals to greater public scrutiny. For example, CMS could require hospitals to provide public notification of CMS enforcement actions via community media outlets or require they publicly post their compliance status on their websites.

To encourage executive accountability for compliance, the Center believes attestation is a stronger requirement than affirmation and supports the proposed rule's provision to rescind existing requirements that a hospital merely make a "good faith effort" to ensure their MRF data are true, accurate, and complete.

The proposed rule's provisions offering a reduced civil monetary penalty may assist compliance-minded, but technically non-compliant, hospitals in achieving full compliance. The Center believes this is a reasonable proposal but may be insufficient to motivate hospitals for which the calculated risk of noncompliance remains an economically preferred choice. The Center believes enhanced enforcement measures may be needed, especially if a hospital accepts this option but remains non-compliant in subsequent filings.

## Comments regarding CMS' Hospital Quality Reporting efforts and Sections X and XX of the Proposed Rule

In general, the Center welcomes CMS's ongoing interest and focused attention in the proposed rule on refining its approach to quality reporting. Although we have no specific comments on the provisions of the proposed rule, we wish to emphasize, for the record, the critical importance of accessible and actionable quality data to purchasers and patients.

We would also like to reiterate our previous recommendation made in the Hospital transparency RFI that CMS require hospitals to post the data that feeds into Hospital Compare and the CMS's quality payment program (QPP) to enable employers and consumers to consider both price and quality information. Alternatively, CMS could post the data on behalf of hospitals. With better data on prices, utilization and quality measures, the Center believes contracting transformation is possible that will lead to better care for patients at a lower cost.

### *Proposed Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments*

In *Section X: Nonrecurring Policy Changes*, CMS is proposing to expand its existing volume control policy to address unnecessary growth in outpatient services delivered in excepted off-campus provider-based departments (PBDs), with a specific focus on drug administration services for calendar year (CY) 2026. This proposal builds on the CY

2019 policy that reduced payment for clinic visits in excepted off-campus PBDs to the Physician Fee Schedule (PFS)-equivalent rate. CMS decided to target drug administration services in light of the significant growth in the volume of these services furnished in excepted hospital outpatient departments (HOPDs), particularly in excepted PBDs. This trend was especially pronounced for high-cost, frequently billed services like chemotherapy administration that are paid nearly three times more when delivered in the HOPD than in a physician office. The shift in the delivery of chemotherapy drugs to outpatient settings also implicates the 340B Drug Pricing program and potential interactions it may have with this proposed policy.

**Site-neutral payment policy has been identified by several of Peterson's grantees as an area that is ripe for bipartisan reform with great potential for generating cost savings without compromising access and quality, when designed with appropriate guardrails.** In the Peterson Foundation's Solutions Initiative 2024, multiple policy organizations across the political spectrum [i.e., the Bipartisan Policy Center (BPC), the American Enterprise Institute (AEI), and the Progressive Policy Institute] highlighted expansion of site-neutral payments as an opportunity to contain costs in Medicare.[10] In May 2025, BPC again highlighted site-neutral payments in Medicare as one of four key bipartisan policy strategies to contain healthcare spending that emerged from a collaboration between health scholars from BPC, AEI, and the Brookings Institution.[11]

Another grantee, the Johns Hopkins University's Center for Health Systems and Policy Modeling (CHSPM) has pursued a body of work on site-neutral payment policy, including an analysis of the impact of various site-neutral policy proposals on Medicare spending (including the relative impacts across hospital types and beneficiary groups),[12] a policy framework for site-neutral payment for ambulatory care, and the impact of participation in 340B on vertical integration under site-neutral payment policies. Our comments below draw on our partnerships with our grantees in this novel research work.

**We support CMS' proposal to apply site-neutral payments to additional outpatient services that can be safely delivered in freestanding physician offices.** Differential payment for the same service in different care settings can drive market behaviors that

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[10] Solutions Initiative 2024: Federal Healthcare Programs. Peter G. Peterson Foundation. July 2024. https://solutions2024.pgpf.org/budget-categories/healthcare/

[11] Hoagland W, Patzman A, Capretta J, Ippolito B, Adler L, Fiedler M. Restraining Health Spending While Protecting Access: Potential For Bipartisan Action. *Health Affairs Forefront*. May 5, 2025. https://www.healthaffairs.org/content/forefront/restraining-health-spending-while-protecting-access-potential-bipartisan-action

[12] Lou K, Linehan K, da Fonte LN, Lai P, Buntin M. Medicare Site-Neutral Payment Policies: Effects of Proposals On Hospitals And Beneficiary Groups. *Health Affairs.* 2025;44(6):668-676. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01501

directly increase Medicare spending.[13] The Center has identified the expansion of site-neutral payment policy as an important deterrent to continued market consolidation and clinically unwarranted increases in Medicare spending. Currently, higher payments to HOPDs for lower-complexity services directly translate into higher costs for Medicare beneficiaries and taxpayers, as hospitals shift care towards higher-paid HOPDs. Further, they indirectly drive up Medicare spending and out-of-pocket costs for beneficiaries by incentivizing consolidation of independent physician practices into hospitals, which is associated with higher prices.[14,15,16] This consolidation has the downstream effect of shifting more billing from the lower independent physician office rates to higher HOPD rates, further increasing total Medicare spending and beneficiary cost-sharing.

**We believe that aligning payments for outpatient services commonly performed in physician offices at a site-neutral rate across ambulatory settings would help address existing incentives for providers to shift care towards higher-paid HOPDs.** Not only would this approach help to reduce unnecessary spending, but it can also steer HOPDs towards offering services that require the resources and expertise of a hospital outpatient setting, freeing up capacity and access and resulting in more efficient resource use. We anticipate this proposal will result in immediate cost savings to Medicare beneficiaries via reduced cost-sharing and will decrease federal Medicare spending over the next decade.

**As such, we support CMS' proposal to apply PFS-equivalent rates for certain drug administration services in off-campus PBDs, and its intent to consider a phased-in approach to including other services and settings, including on-campus clinic visits.** Applying site-neutral payment to the four drug administration Ambulatory Payment Classification codes (APCs) at off-campus HOPDs has been estimated to result in substantial savings for the Medicare program and for beneficiaries.[17,18] On the

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[13] Cooper Z, Jurinka E, Stern D. Review of Expert and Academic Literature Assessing the Status and Impact of Site Neutral Payment Policies in the Medicare Program. Yale Tobin Center for Economic Policy. October 30, 2023. https://tobin.yale.edu/research/review-expert-and-academic-literature-assessing-status-and-impact-site-neutral-payment-policies

[14] Dranove D, Ody C. Employed for Higher Pay? how Medicare Payment Rules Affect Hospital Employment of Physicians. *American economic journal. Economic policy*. 2019;11(4):249–271. https://www.aeaweb.org/articles?id=10.1257/pol.20170020

[15] Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration between Physicians and Hospitals with Commercial Health Care Prices. *JAMA internal medicine*. 2015;175(12):1932–1939. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591

[16] Post B, Norton EC, Hollenbeck B, Buchmueller T, Ryan AM. Hospital-physician Integration and Medicare's Site-based Outpatient Payments. *Health services research*. 2021;56(1):7–15. https://pmc.ncbi.nlm.nih.gov/articles/PMC7839648/

[17] Lou K, Linehan K, da Fonte LN, Lai P, Buntin M. Medicare Site-Neutral Payment Policies: Effects of Proposals On Hospitals And Beneficiary Groups. *Health Affairs.* 2025;44(6):668-676. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01501

[18] Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act. Congressional Budget Office. December 8, 2023. https://www.cbo.gov/system/files/2023-12/hr5378-DS-and-Revs_12-2023.pdf

question of patient safety, in their aforementioned study on site-neutral policy proposals, the CHSPM at Johns Hopkins found that 46.8 percent of the four drug administration APCs were performed in physician offices, which aligns with other research conducted by MedPAC and others on the safety of delivering services in freestanding physician offices.[19,20] For a phased-in approach of future services and settings, when evaluating whether services can be safely delivered in physician offices, CMS should draw on historical data predating widespread consolidation of physician offices to ascertain whether shifts in sites of service were driven by clinical innovation or by consolidation / responses to perverse payment incentives.

**Finally, when proposing site-neutral payment policy changes, we encourage CMS to consider their interaction with other existing policies that may potentially stymie progress towards the ultimate policy goal.** In another CHSPM study (currently undergoing peer review at an academic journal), their findings suggest that newly participating in the 340B program led to a higher volume of drug administration services in off-campus HOPDs, even though they were subject to site-neutral payments. This could indicate that 340B participation offers hospitals an additional incentive to increase drug administration services at off-campus HOPDs even when site-neutral payment is in place.

### *Proposed Market-Based Medicare Severity-Diagnosis Related Groups (MS-DRG) Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights under the Inpatient Prospective Payment System*

In *Section XX, Proposed Market-Based Medicare Severity-Diagnosis Related Groups (MS–DRG) Relative Weight Data Collection and Change in Methodology for Calculating MS–DRG Relative Weights Under the Inpatient Prospective Payment System*, CMS is reintroducing a previous proposal to require hospitals, beginning January 1, 2026, to include in their Medicare cost report the median payer-specific negotiated charge for each MS-DRG that a hospital negotiated with all the Medicare Advantage Organizations (MAOs) with which it is contracted. This information would be used to inform a market-based MS-DRG relative weight methodology, effective for the relative weights calculated for FY 2029. It is especially important to collect and include MAO payment rates now that over half of Medicare beneficiaries receive their coverage through Medicare Advantage (MA) plans.[21]

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[19] Lou et al.
[20] Medicare and the Health Care Delivery System – Chapter 8: Aligning fee-for-service payment rates across ambulatory settings. Medicare Payment Advisory Commission. June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[21] Medicare Advantage in 2025: Enrollment Update and Key Trends. Kaiser Family Foundation. July 28, 2025. https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/

**We support CMS' proposal to require the reporting of this data on the Medicare cost reports.** If finalized, this information will help fill a critical gap in price transparency data and represents a meaningful step towards developing an alternative approach to determine Medicare payment that does not rely on hospital chargemaster rates, which CMS describes as inflated and not reflective of true market rates.

Currently, researchers have limited visibility into the payment arrangements between MA plans and providers, which impedes research on the value that MAOs are delivering and the impacts of the MA program on providers and beneficiaries. This is because the MA encounter data made available to researchers does not include rate information due to regulations restricting its release to the public. If this proposal is finalized, the newly reported data could support analysis of the effects of MA plan market concentration on negotiated prices with contracted hospitals, compared to Medicare fee-for-service and other payers. These analyses would provide novel insights into whether reports of hospitals facing financial challenges from MA are accurate, and if so, attempt to estimate whether those challenges can be attributed to lower payment, MAOs denying payment, payer mix or other factors. This data would also provide greater transparency to study whether cost-shifting is occurring between MA plans and commercial plans – important information purchasers and policymakers need to effectively reduce the total cost of healthcare.

As CMS notes, it is well understood that hospital chargemasters are highly inflated relative to market rates and that these artificially inflated charges are often used to obtain higher payments from Medicare and private payers. **We welcome the exploration of an alternative approach to establishing Medicare payment for hospitals that is informed by empirical data and promotes greater transparency and efficiency in the healthcare system.**

Furthermore, hospitals have already been required for the last four years to include the median payer-specific negotiated charge for MA in the HPT MRFs and should have gained adequate experience in reporting this data. While this information is already technically publicly available, as we have detailed extensively in these comments, these data files are extremely cumbersome to work with and currently require extensive and expensive analytical support to generate actionable information. Requiring this data in the Medicare cost reports will help to ensure data integrity of this critical information and make it more accessible to researchers and the public.