CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

August 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Re: Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P)

Submitted electronically via Regulations.gov

Dear Administrator Oz,

On behalf of *Consumers First,* an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of our health care system, thank you for the opportunity to comment on the Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2027.

One essential lever to ensuring the economic incentives that underlie our health care system drive the delivery of affordable, high-quality care is the enactment of improved Medicare payment policy, which in turn establishes a standard that is often adopted by commercial payers and Medicaid. ***Consumers First* sees this rule as an important step towards realigning the fundamental economic incentives in our health care payment and delivery system to lower hospital costs and improve health, and we offer comments to both support and strengthen several of the proposals outlined by the Centers for Medicare & Medicaid Services (CMS).** These proposed payment changes could catalyze the transformational reform that is needed to ensure our payment systems drive high value care across the country.

The comments in this letter represent the views of the *Consumers First* steering committee and other signers. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments are focused on three sections of this year's proposed rule:

- **X. A.** Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

- **XX.** Codification of Section 6225 of the Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status (§§ 413.65 and 419.23)
- **XXIII.** Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data

X. A. Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

Site Neutral Payments for Imaging Without Contrast Services

Consumers First **strongly supports CMS' proposal to extend site neutral payments to imaging without contrast services at certain off-campus provider-based departments.** *Consumers First* has long urged CMS to expand its site neutral payment policy to additional services and sites of service – essential steps to end the longstanding distortion in Medicare reimbursement that incentivizes hospitals to push patients to costlier care settings and to purchase independent doctors' offices in order to generate higher reimbursements.[1] This arbitrary payment disparity is a major driver of the growing trend of consolidation between hospitals and physician practices and is a significant root cause of high U.S. health care costs.[2]

Building on prior Congressional and administrative efforts, CMS proposes to take an additional step to addressing site of service payment differentials by extending site neutral payments to Ambulatory Payment Classifications (APCs) for imaging services without contrast delivered at "grandfathered" off-campus provider-based departments (PBDs).[3] Specifically, CMS proposes to apply the site-specific Medicare Physician Fee Schedule (MPFS) rate for non-excepted items and services delivered by non-excepted sites of service in a non-budget neutral manner.[4] These services include X-rays, ultrasounds, computer tomography (CT), magnetic resonance imaging (MRI), and more, which MedPAC and other experts indicate can be safely and efficiently delivered at independent doctors' offices.[5]

CMS estimates this proposed site neutral policy would generate $190 million in savings to Medicare in 2027 alone – alongside $70 million in direct savings for Medicare beneficiaries that same year – and an overall $7.2 billion reduction in Medicare program spending over 10 years.[6] Moreover, because Medicare often sets the benchmark for how other insurers pay for health care, enacting broader site neutral payments in Medicare would not only result in significant savings for those with Medicare coverage but also for patients with commercial insurance.[7] It is estimated that implementation of site neutral payments could result in $107 billion in lower premiums for private plans over 10 years.[8]

This proposal represents a critical step to ensuring consumers and health care purchasers pay the same price for the same service for a greater share of the routine health services that MedPAC and other experts have cited can be safely and cost-effectively delivered to patients regardless of site of service, including in this case the 1.6 million Medicare patients who obtain MRIs and other imaging services every year.[9,10] As such, ***Consumers First*** **strongly supports**

CMS's site neutral proposal that would apply the MPFS rate for certain imaging services. At the same time, *Consumers First* recommends that CMS go further and maximize the use of its regulatory authority to expand site-neutral payments to additional sites of care and services. Specifically, we recommend CMS:

- **Eliminate the "grandfathering" of higher OPPS payment rates for existing off-campus PBDs for all services.** The Congressional Budget Office (CBO) previously estimated that closing this loophole would save $13.9 billion between 2019 and 2028.[11]
- **Extend site-neutral payments for clinic visits to all on-campus PBDs.** MedPAC's 2017 report estimated that implementing site-neutral payments for clinic visits at on- and off-campus PBDs would save Medicare almost $2 billion a year.[12]
- **Extend site-neutral payments across a broader set of 66 clinical services**, including:
    - The 57 Ambulatory Payment Classifications (APCs) identified in the June 2022 MedPAC Reporting (and following reports) to Congress, to align the OPPS and alternate care site payment rates with those set in the MPFS;[13] and
    - The 9 APCs that should align the OPPS payment rates with the ambulatory service center (ASC) payment rates and continue to use the MPFS rate when the service is provided in a freestanding medical office.[14]

Eliminating site-of-service payment incentives in the Medicare program is one of the most effective solutions to address hospital consolidation, and CMS should do everything it can to make payment changes that work toward that goal. Enacting comprehensive site neutral payment policies would result in significant saving for consumers and the Medicare program: in 2024, the CBO estimated that a comprehensive site neutral policy would save Medicare approximately $157 billion over ten years.[15]

<u>Exemptions for Rural Sole Community Hospitals</u>

***Consumers First* recommends CMS refine its proposal to exempt rural Sole Community Hospitals (SCHs) from site neutral payments for imaging without contrast services to better target select rural providers, particularly rural independent hospitals, most at risk of service reductions or financial instability. Similarly, we urge CMS to revisit and refine its policy that exempts rural SCHs from site neutral payments for the delivery of clinic visits and drug administration in "grandfathered" off-campus PBDs.**

CMS proposes to exempt rural Sole Community Hospitals from their proposed equalization of payment for imaging without contrast services as discussed above.[16] The proposal to exempt rural SCHs in this year's proposed rule builds on CMS' existing policy that exempts these hospitals from being paid the site neutral payment rate for clinic visits and drug administration services delivered in excepted off-campus hospital outpatient departments (HOPDs).[17] Rural Sole Community Hospitals are defined as hospitals located in non-metropolitan areas with less

than 50,000 residents that are more than 35 miles away from other hospitals, or serve patient populations of which 25 percent or less are admitted to other hospitals located within a 35-mile radius.[18]

Enacting site neutral payments is a key tool for promoting healthy competition in rural communities and lowering health care costs for rural families.[19] Site-specific payments are generally unrelated to the actual cost of providing routine care in the least expensive setting that is safe and appropriate, and waiving such payments for large swaths of rural providers would continue to encourage system consolidation and other forms of industry gaming that harm the health and financial security of rural consumers with higher out-of-pocket costs.[20] Given that rural hospital markets are already highly concentrated due to unchecked health care consolidation and resultant price increases, rural Americans face high and rising health care costs, significant provider shortages and more limited choices of where they can receive care.[21]

Consumers First recognizes that certain rural and safety net providers may require tailored financial support to help sustain health care delivery and access in rural and underserved areas as they transition to site-neutral payments. However, CMS should design that support in a targeted way. Waiving site neutral policies for broad categories of hospitals risks undermining the goal of site neutral payments and exacerbating the problem it is designed to solve.[22] Specifically, Medicare's definition of "rural Sole Community Hospital" poorly targets the rural and safety-net hospitals that are truly in need of any such payment adjustment.[23] The Sole Community Hospital designation is broad enough to include both hospitals that predominately serve higher income communities with significant shares of patients with commercial insurance and hospitals that are owned by monopolist systems and charging irrational prices for their care.[24] For example, the Mayo Clinic Health System is a near monopolist non-profit health system in southeast Minnesota which makes over $1 billion a year in net income and operates two hospitals in Fairmont and Austin, MN that are identified as rural Sole Community Hospitals.[25] Rural hospitals affiliated with large corporate health systems have a very different financial outlook than independent rural hospitals and are more able to absorb the financial impact of changes to site-of-service payment differentials.[26] By exempting all rural Sole Community Hospitals, CMS risks allowing large corporate health systems to continue to charge inflated prices for routine care that should otherwise be paid at the site neutral rate while generating significant profits and margins at the expense of the health and financial security of rural communities across the nation.[27]

More tailored exemptions for certain rural independent hospitals, or delaying/phasing-in implementation of site neutral payments for such hospitals, is a reasonable policy approach to implementing site neutral payments while mitigating any disproportionate impact on those rural hospitals that have greater financial uncertainty. **To that end, when considering any**

exemptions from site-neutral payment requirements, *Consumers First* would urge CMS to take a more surgical approach by targeting exemptions for independent rural hospitals – hospitals not affiliated with large corporate systems.

XX. Codification of Section 6225 of the Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status (§§ 413.65 and 419.23)

***Consumers First* strongly supports CMS' proposal to codify and implement requirements that off-campus hospital outpatient departments use a unique and separate National Provider Identity when billing Medicare, as established by the Consolidated Appropriations Act of 2026.** Beginning in January 2028, the Consolidated Appropriations Act of 2026 prohibits off-campus outpatient department providers from receiving OPPS payments under Medicare unless the provider uses a separate National Provider Identity (NPI) from their "main provider" (that is, the on-campus hospital system). Moreover, such hospitals are required to submit specific attestation that the provider meets requirements for being a provider-based department.[28]

Prior to the enactment of this "fair billing" policy, hospitals would bill for services furnished at off-campus outpatient departments using a single, hospital-level NPI shared with the main campus. This practice prevented CMS, researchers, and other policymakers and payers, from distinguishing a service performed at the hospital itself from one performed at a physician's office the hospital acquired and then billed as hospital outpatient care. Because Medicare pays substantially more for the same service under OPPS than under the Physician Fee Schedule, this shared NPI structure let hospitals convert acquired physician offices into higher-paid hospital outpatient departments with no way to see that conversion in the claims data. Without the unique NPI requirement, payers, including CMS, had little ability to distinguish between care being delivered at on-campus versus off-campus HOPDs, creating a loophole for hospitals to overbill payers and consumers. **As such, *Consumers First* strongly supports CMS codifying and implementing requirements passed by Congress in the CAA of 2026 to ensure off-campus HOPDs use a unique NPI when billing Medicare, and we urge CMS to work with federal lawmakers to expand and apply such billing transparency reforms to commercial insurers as well.**

XXIII. Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data

Consumers First has long supported CMS' efforts to increase hospital price transparency as a key tool to address the impact of widespread health care industry consolidation across and within U.S. health care markets on high and rising health care prices, by empowering consumers, employers and other purchasers with accurate and actionable pricing

information.[29] In the CY2027 OPPS propose rule, CMS requests additional information that could be considered for inclusion in the machine-readable file (MRF) "to enhance the utility and comparability" of the pricing data.[30] Ultimately, ***Consumers First*** **believes the most important step that CMS could take to enhance the comparability and usefulness of the hospital price transparency data is to require hospitals to post their negotiated rates in dollars and cents without exception, and to reverse previously finalized policies that allow hospitals to post price estimates or ranges.**

In the CY2024 OPPS rule, CMS finalized a policy that allowed hospitals to post an "estimated allowed amount."[31] In the CY2026 OPPS final rule, CMS replaced this policy with four new data elements when the reported negotiated rate is based on an algorithm or percentage: "median allowed amount," "10th percentile," "90th percentile," and "count of allowed amounts."[32] The "median allowed amount" defines the median price paid based on historical health care payments received by the hospital in the up to 12 months prior to the posting of the MRF.[33] However, the only data point that actually unveils the true price of health care services is the negotiated rate. Estimates, medians, averages and percentile are all pieces of information that allow for limited insight into pricing practices, but without the actual negotiated rate, consumers and health care purchasers remain blind when shopping for care and negotiating for lower costs. Importantly, if hospitals can generate a bill based off the negotiated rates for each item and service, then they should be able to share those prices up front with the actual purchasers of health care.

Moreover, it is now well understood that negotiated rates are available through the Transparency in Coverage data files.[34] This means that, despite hospital claims that they can't produce the negotiated rates or that they only have the data in the form of algorithms, the negotiated rate data *does* exist and *can* be shared.[35] Now it is up to policymakers to ensure hospitals actually disclose those health care prices publicly without forcing consumers and health care purchasers to rely on inaccessible third-party vendors to translate the data into meaningful pricing information.[36] ***Consumers First*** **urges CMS to explicitly require hospitals to display all standard charges, and specifically the negotiated rate, in dollars and cents, and reverse policies that allow hospitals to post any standard charges in the form of algorithms, percent of Medicare, "N/A's", and price estimates. Only the negotiated rate, displayed in dollars and cents should be considered complete and accurate information for the purposes of the hospital price transparency rule.**

Moreover, there are a number of additional commonsense policies that CMS should implement to further increase the reliability and usefulness of published hospital pricing data as well as hospital compliance with the federal Hospital Price Transparency Rule. *Consumers First* recommends that CMS take the following actions:

- **Increasing the civil monetary penalty (CMP) for noncompliance to $300 *per bed per day* for hospitals with 31 or more beds and remove the annual $2 million cap on the CMP for such hospitals.** This will send a stronger message to hospitals that it is imperative that they post complete, accurate pricing information.
- **Requiring that the senior officials whose names are encoded into the MRF sign the attestation via verified electronic signature.** While requiring hospitals to identify and encode the name of a senior official designated to be responsible for accuracy of the price transparency data is an important step, there needs to be stronger accountability for that hospital official. *Consumers First* believes requiring that the official sign their name, through a verified electronic signature, will build the level of accountability needed to ensure accuracy and completeness of the hospital pricing information in the MRF.
- **Requiring that hospitals, over time, publish and pair quality information with pricing information. CMS should establish a process, or build on existing processes, to engage a wide range of non-industry stakeholders to determine what kinds of quality information would be most appropriate and meaningful to pair with published prices.** Ultimately, for there to be meaningful oversight of the health care industry, both pricing information and information about the quality of care a hospital provides should be publicly available to researchers, policymakers, and consumers. We understand that additional work is needed to arrive at, and report on, a harmonized set of meaningful quality measures, but requiring hospitals to disclose quality data alongside existing price data is a critical step in providing meaningful transparency into the value and cost-effectiveness of hospital care, and ultimately the health care system more broadly.[37]

On behalf of *Consumers First* and our undersigned partners, we thank you again for the opportunity to comment on the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for Calendar Year 2027, and for considering the above recommendations. Please contact Aaron Plotke, Associate Director for Health Care Financing and Pricing at Families USA at aplotke@familiesusa.org for further information.

Sincerely,

***Consumers First* Steering Committee**
American Academy of Family Physicians
American Benefits Council
Families USA
Purchaser Business Group on Health

Partner Organizations
American Institute on Disparities in Public Health

Arkansas Community Organizations
Association for Independent Medicine
Autistic Women & Nonbinary Network
California Health Advocates
Center for Public Health Education and Advocacy
Citizen Action of Wisconsin
Colorado Consumer Health Initiative
Committee to Protect Health Care
Consumers for Affordable Health Care
Democratic Disability Caucus of Florida
Equitas Health
Iowa Citizen Action Network
Kentucky Voices for Health
Latino Texas Policy Center
Mental Health Partnerships
National Association of Social Workers (NASW)
National HIV & Aging Advocacy Network
National Advocacy Center of the Sisters of the Good Shepherd
New Jersey Appleseed Public Interest Law Center
NJ Association of Mental Health & Addiction Agencies
Northwest Health Law Advocates
Pennsylvania Health Access Network
Public Sector HealthCare Roundtable
Serving At-Risk Families Everywhere, Inc.
Small Business Majority
Society for Public Health Education
The ERISA Industry Committee (ERIC)
Treatment Communities of America
U.S. PIRG
Vermont-National Education Association

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