September 12, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS–1834–P: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz:

On behalf of Iowa's 123 hospitals, including 33 prospective payment system hospitals, the Iowa Hospital Association (IHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the Calendar Year (CY) 2026 Outpatient Prospective Payment System (PPS). IHA further expresses support for the comments submitted by the American Hospital Association.

To understand the context within which Iowa hospitals are operating and the rationale behind our comments on the proposed rule, it is important to consider their pivotal role in supporting both the health and economic stability of the state and its communities. Their impact is substantial, as evidenced by the following:

2024 Economic Contributions

- **Employment**: Iowa hospitals provide $9.6 billion in wages and benefits, supporting 72,000 direct jobs.
- **Job Support**: They indirectly support just under 142,000 additional jobs across the state.
- **Economic Impact**: Hospitals contribute $22.9 billion to Iowa's economy, accounting for 12% of the state's gross domestic product.

2024 Community Benefits

- **Contributions**: Hospitals delivered more than $1.1 billion in community benefits
- **Charity Care**: Provided $280 million in charity care, aiding those unable to afford medical services.

Despite these significant contributions, Iowa hospitals face several challenges that threaten their financial stability and capacity to serve the community effectively. Key trends and issues include:

Shifts in Care Patterns

- There is a notable increase in outpatient care combined with a decrease in inpatient care, impacting the revenue models of hospitals.

Public Payor Dependence

- The 2024 average payor mix for Iowa hospitals underscores a substantial reliance on public programs, with 60% of total revenue originating from these sources—44% from Traditional Medicare and Medicare Advantage, and 16% from Medicaid.

Financial Pressure

- 42% of Iowa hospitals operate with negative or unsustainable margins.
- Inflation and other factors drove a $2.3 billion increase in expenses from 2021 to 2024, including:
  - An additional $163 million spent on supplies
  - Contracted labor costs increased $257 million
  - Pharmaceutical expenses rose $329 million
  - Payroll and benefits increased by $800 million

Iowa hospitals are essential to the state's health and economic well-being but are currently operating under significant financial strain. These challenges underscore the importance of supportive policies and adequate funding to ensure these institutions can continue to provide vital services and maintain their crucial role in the community.

Outpatient PPS Payment Update
For Calendar Year 2026, CMS has proposed a national market basket update of 3.2%, offset by a 0.8 percentage point productivity adjustment, resulting in a net payment increase of just 2.4%. In Iowa, the update is estimated to be a 1.51% increase. However, after accounting for the 2% Medicare sequestration, the estimated net increase drops to only 0.88%. Further, the agency notes that under its 340B remedy offset proposal, payments for services at hospitals subject to the remedy offset will be reduced by 2.0 percentage points. While this methodology follows statutory and regulatory requirements, the resulting update does not adequately reflect the persistent financial pressures hospitals face. When combined with years of insufficient updates, this proposal further compounds Medicare's chronic underpayments to hospitals and health systems.

IHA urges CMS and policymakers to reexamine the assumptions and methodologies used in determining Medicare payment rates. The current time-lagged approach fails to capture the real-time economic conditions hospitals are navigating, particularly the sustained inflation in labor, supply, and infrastructure costs detailed above. As a result, the proposed 2.4% update

falls short of what is needed to maintain access to care and financial stability across the hospital sector.

This concern is especially urgent given the broader fiscal landscape. Without a more responsive and data-driven approach to Medicare rate-setting, hospitals will face mounting challenges in delivering high-quality care to Medicare beneficiaries.

Proposed Site-Neutral Payment Policies for Off-Campus Provider-Based Departments
As background, Section 603 of the Bipartisan Budget Act of 2015 requires that services, except for dedicated emergency department (ED) services, furnished in off-campus provider-based departments (PBDs) that began billing under the OPPS on or after Nov. 2, 2015, or that cannot meet the 21st Century Cures Act "mid-build" exception, will no longer be paid under the OPPS, but under another applicable Part B payment system. For 2026, the agency continues to identify the Physician Fee Schedule (PFS) as the applicable payment system for most of these non-grandfathered (non-excepted) services and sets this site-neutral payment rate at 40% of the OPPS rate.

In the CY 2019 OPPS/ASC final rule, CMS applied a previously unused statutory authority to develop a "method to control for unnecessary increases in the volume of outpatient services." Under this method, CMS pays the site-neutral rate for clinic visit services furnished in off-campus PBDs that had previously been protected from site-neutral provisions under the Bipartisan Budget Act of 2015. For CY 2026, CMS will continue to pay for hospital outpatient clinic visit services furnished in grandfathered (excepted) off-campus PBDs at 40% of the OPPS payment amount. It also will continue to exempt excepted off-campus PBDs of rural sole community hospitals (SCHs) from this clinic visit payment policy.

CMS claims that financial incentives continue to drive service volume increases in hospital outpatient departments (HOPDs), particularly for drug administration services, leading to "unnecessary" Medicare spending and higher out-of-pocket costs for beneficiaries. The agency attributes this trend to site-of-service payment disparities and hospital acquisitions of physician practices, which enable billing at higher hospital-based rates. Therefore, starting in CY 2026, CMS proposes to again use the statutory authority described above to impose a site-neutral payment reduction. Under its proposal, it would pay the site-neutral rate of 40% of the OPPS rate for drug administration procedures furnished in grandfathered (excepted) off-campus PBDs, which is an estimated $1.5 million payment reduction for Iowa hospitals in 2026.

IHA is strongly opposed to the proposed expansion of site-neutral payment policies for drug administration services in grandfathered off-campus HOPDs. These departments are held to significantly higher regulatory and safety standards than freestanding physician offices. Hospitals must maintain sterile environments, including clean rooms with positive air pressure, and conduct environmental sampling to prevent microbial contamination. Drug preparation is supervised by licensed pharmacists, and hospitals implement strict protocols to protect staff from exposure to hazardous drugs. Moreover, hospitals are equipped to make real-time clinical adjustments and respond to adverse drug reactions with on-site physicians and emergency infrastructure.

These standards are not optional; they are mandated by the Food and Drug Administration,

U.S. Pharmacopeia, The Joint Commission, and state boards of pharmacy. Applying site-neutral payment rates disregards these differences and creates a false equivalence between fundamentally different care environments. The proposed policy would significantly reduce reimbursement for services that require a higher level of safety and oversight, threatening access to care for medically complex patients, particularly in rural and underserved communities where HOPDs are often the only source of outpatient specialty care. As such, IHA urges the agency to abandon its proposal to expand site-neutral payment policies for drug administration services.

Proposal to Expedite Recoupment Timeline Under 340B Remedy Rule

In the proposed rule, CMS proposes to accelerate the clawback of $7.8 billion in OPPS payments stemming from its unlawful 340B policy from 16 years to just six years while increasing the annual clawback rate from 0.5% to 2.0%. This suggested change would create significant cash flow challenges for hospitals and would jeopardize service availability, particularly for vulnerable populations. We urge CMS to reconsider this proposal as it does not consider the financial realities hospitals face: rising costs, persistently inadequate reimbursements, and the anticipated effects of recent legislation such as the One Big Beautiful Bill Act. These pressures are not theoretical—they are already reshaping hospital operations and threatening access to care.

Hospitals began preparing for the clawback as soon as CMS announced it in 2023. Budgets, staffing, capital investments, and service expansions were all calibrated to absorb a 0.5% annual reduction. Finalizing a fourfold increase just months before implementation would upend these plans, destabilize operations, and undermine trust in regulatory consistency. If CMS continues to reject the legal arguments against the clawback, it must at least preserve or extend the original timeline to avoid destabilizing hospital finances and compromising patient care.

Hospital Drug Acquisition Cost Survey

CMS's proposal to conduct a nationwide drug acquisition cost survey of all hospitals paid under the OPPS, announced in the CY 2026 proposed rule, should be withdrawn. This initiative, stemming from Executive Order 14273 ("Lowering Drug Prices by Once Again Putting Americans First"), would impose significant and unnecessary administrative and financial burdens on hospitals and their staff. Even more troubling is its apparent objective: to justify reductions in Medicare reimbursement beginning in CY 2027.

Drug acquisition cost surveys are inherently labor-intensive and costly. CMS estimates that each hospital would spend 73.5 hours and approximately $4,000 to complete the survey. However, both historical precedent and real-world experience suggest these figures are grossly underestimated. The Government Accountability Office's 2006 report to Congress confirmed that such surveys "created a considerable burden for hospitals"—a reality that remains unchanged today.

More fundamentally, the survey's intended outcome, further cuts to Medicare reimbursement, is deeply problematic. Medicare already reimburses hospitals at rates well below the cost of care, nationally covering only 83 cents for every dollar spent in 2023. This underpayment resulted in over $100 billion in losses across the hospital sector. Between 2022 and 2024, general inflation rose by 14.1%, while Medicare inpatient payment rates increased by only 5.1%, effectively

amounting to a real cut. In December 2024, the Medicare Payment Advisory Commission reported that hospital Medicare margins had fallen to a historic low of -12.6%, with continued financial strain projected for 2025. Any additional reductions would be unsustainable and would jeopardize access to care for millions of patients.

In addition to its financial implications, the survey lacks a sound legal foundation. CMS cites Section 1833(t)(14)(D)(iii) as its authority, but this provision merely outlines survey requirements, it does not authorize CMS to mandate participation or impose penalties for non-compliance. If Congress had intended to require hospital participation, it would have done so explicitly, as it has in other regulatory contexts. CMS must therefore clarify in the final rule that participation in the survey is strictly voluntary.

Recognizing this legal limitation, CMS has proposed several methods for interpreting non-responses. However, none of these approaches satisfy the statutory requirement for a "statistically significant estimate" of average acquisition costs. Attempting to fabricate data from non-responses undermines the integrity of the survey and risks producing misleading and unreliable results. If CMS is concerned about low response rates, the appropriate response is not to reinterpret silence as data but to reconsider the survey altogether.

We urge CMS to abandon this proposal. It imposes undue burdens, lacks legal authority, and serves a misguided goal that would further destabilize hospital finances. We welcome the opportunity to work with CMS on alternative strategies that promote transparency without compromising access to care or the financial viability of hospitals.

Proposed Elimination of the IPO List
Within the proposed rule, CMS proposes to phase out the Inpatient Only (IPO) list by January 1, 2029, beginning with the removal of 285 procedures in CY 2026. While hospitals appreciate CMS's intent to allow physician judgment to guide decisions about inpatient necessity, this proposal raises significant issues that warrant further consideration.

The elimination of the IPO list may inadvertently undermine physician autonomy, particularly in the context of payer practices. Although CMS and Traditional Medicare support clinical discretion, commercial payers, including Medicare Advantage plans, may use this change to impose stricter criteria that override physician judgment. For example, some payers may disregard the Two-Midnight Rule and enforce more rigid standards for inpatient admissions. To safeguard clinical decision-making, CMS should establish clear criteria for inpatient admissions and actively monitor Medicare Advantage plan denials to ensure services are not inappropriately denied.

Additionally, the proposal could have unintended consequences for beneficiary cost sharing. While CMS suggests that single-episode payments may reduce financial burdens, hospitals caution that patients may still face multiple co-payments and deductibles due to separate billing for professional and facility services. This could result in increased out-of-pocket costs for beneficiaries, particularly for complex procedures.

There are also concerns about the potential impact on care quality and access. Eliminating the IPO list may reduce hospital reimbursement by shortening inpatient stays, which could incentivize early discharges and compromise patient safety. Furthermore, this change could

affect the three-day inpatient stay requirement for skilled nursing facility coverage, potentially limiting access to post-acute care. The proposed three-year phase-out may be too aggressive, especially for high-risk procedures such as organ transplants and open-heart surgeries. CMS should consider excluding such procedures from outpatient settings or extending the transition timeline to ensure safe implementation.

Considering these concerns, we urge CMS to proceed cautiously with the elimination of the IPO list. A more measured approach that protects physician autonomy, ensures appropriate reimbursement, and safeguards patient access and safety would better serve the health care system and its beneficiaries.

Outpatient Quality Reporting Program

CMS proposes to remove several existing measures, including COVID-19 Vaccination Coverage Among Healthcare Personnel, Hospital Commitment to Health Equity, and Screening for and Positive Rates of Social Determinants of Health (SDOH). IHA supports the removal of these measures. The COVID-19 vaccination measure has become outdated and increasingly difficult to report accurately, and it no longer reflects current public health priorities. Similarly, the health equity and SDOH measures, while important, have proven challenging to implement due to limited infrastructure, staff capacity, and training across many hospitals. Hospitals emphasize the need for clear and coordinated plans of care that span inpatient and outpatient settings, and the ability to share information seamlessly is essential to achieving meaningful progress in these areas.

CMS also proposes to replace existing ED measures with a new Emergency Care Access and Timeliness electronic clinical quality measure (eCQM), which includes metrics such as wait times over one-hour, boarding times over four hours, length of stay over eight hours, and rates of patients leaving without being seen. While the goal of improving emergency care is commendable, there are concerns about fairness and transparency in public reporting. Hospitals may be penalized for systemic issues beyond their control, such as shortages of behavioral health beds or delays in emergency medical transportation. Smaller EDs with limited resources may be disproportionately affected. Additionally, because this is an eCQM rather than a chart-abstracted measure, hospitals are concerned about the accuracy of time capture, especially during high-acuity events like trauma cases. Electronic medical record timestamps may not reliably reflect actual arrival or treatment times, which could lead to misleading data.

Stakeholders also recommend stratifying the data to account for behavioral health and trauma patients, who may require different metrics. Including measures related to post-ED bed availability and transport delays would provide a more complete picture of emergency care access and performance.

Regarding the Excess Radiation Dose eCQM, there is strong support for maintaining voluntary reporting indefinitely. Further, hospitals have raised concerns about the financial burden of implementing new software and the complexity of defining “excess” radiation. Factors such as body habitus, chronic health conditions, and diagnostic needs—particularly in oncology patients—must be considered to avoid penalizing appropriate clinical care.

In summary, while we support CMS’s efforts to modernize and improve the OQR Program, we

urge the agency to proceed thoughtfully. Ensuring fairness, accuracy, and feasibility in reporting will be critical to the success of these measures and to maintaining trust among providers and patients.

Proposed Modifications to the Overall Star Rating Methodology
CMS proposes a two-stage approach to modifying the star rating system: first, capping hospitals in the lowest quartile of the Safety of Care domain at a maximum of four stars beginning in CY 2026; and second, automatically reducing the Overall Star Rating by one star for hospitals in that same quartile starting in CY 2027.

IHA opposes these proposed changes. The methodology appears punitive and may misrepresent hospital performance to the public. Star ratings are often based on data that is two to three years old, which does not accurately reflect current safety and quality. Moreover, a single adverse event can disproportionately impact a hospital's score, even if the issue is promptly addressed and resolved.

There are also significant concerns regarding transparency and predictability. Hospitals lack clarity on peer groupings and the timeframes used in the ratings, making it difficult to anticipate or manage their performance under this system. Additionally, the public may misinterpret outdated ratings as indicative of current care quality, which undermines the intent of the star rating system.

To improve the accuracy and fairness of the ratings, hospitals urge CMS to consider using real-time or near-real-time data sources, such as electronic clinical quality measures (eCQMs), to better reflect current performance. Rather than applying blanket penalties, CMS should explore contextualized reporting that accounts for hospital size, case mix, and improvement efforts. Furthermore, public education should be enhanced to clarify how ratings are calculated and what they represent. We encourage CMS to pursue a more balanced and transparent approach that supports continuous improvement while providing meaningful information to patients and stakeholders.

Changes to the Hospital Price Transparency Requirements
IHA is also deeply concerned about the proposed changes to hospital price transparency requirements. Hospitals nationwide have made commendable strides in complying with the Hospital Price Transparency Rule. CMS data show that in 2022, nationally 70% of hospitals were fully compliant with both the machine-readable file (MRF) and shoppable services requirements, a dramatic improvement from 27% in 2021. Hospitals have invested heavily in technology, staff training, and data infrastructure to meet these requirements.

The proposed addition of new data elements to the MRF, including median, 10th percentile, and 90th percentile allowed amounts, as well as the count of allowed amounts, adds undue complexity and administrative burden. Hospital pricing is inherently variable and context-specific, influenced by patient acuity, bundled services, and payer-specific cost-sharing rules. Calculating percentile values from remittance data may not yield meaningful or comparable results across hospitals. Moreover, CMS's proposed use of EDI 835 electronic remittance advice (ERA) data may not be feasible for all hospitals, particularly smaller and rural providers with limited technical capacity. The estimated one-time cost of $478 per hospital significantly

understates the true burden of implementing these changes.

Hospitals must also navigate overlapping federal and state transparency mandates, including the Hospital Price Transparency Rule, the Transparency in Coverage Rule for insurers, and the No Surprises Act. Each policy uses different methodologies and formats, leading to inconsistent information and patient confusion. Patients may receive pricing data from hospital MRFs, cost estimator tools, insurer platforms, and Good Faith Estimates. We encourage CMS to collaborate with other agencies to align and streamline transparency requirements, ensuring that patients receive consistent, understandable information.

Thank you for considering our comments. We look forward to continuing collaboration with CMS to ensure these regulations are both fair and effective.

Sincerely,

Chris Mitchell
President/CEO
Iowa Hospital Association