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

September 15, 2025

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention: CMS-1834-P
P.O. Box 8016 Baltimore, MD 21244–8016

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

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 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2026.

The members of *Consumers First* work together to hold the nation's health care system accountable to providing everyone with affordable, high-quality, cost-effective care. One essential lever to achieving this goal 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* offers these comments to both strengthen hospital outpatient payments and to acknowledge this rule as an important step towards realigning the fundamental economic incentives in our health care system to meet the needs of all families, children, seniors, adults, and employers by lowering health care costs and improving health. At the same time, *Consumers First* will continue to urge Congress to build upon any administrative rulemaking and pass legislation that helps achieve meaningful transparency and competition in health care, and the delivery of affordable, high value care, such as by increasing hospital price transparency and expanding site neutral-payment policies. These proposed changes could catalyze the transformational change 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 undersigned *Consumers First* steering committee and other partners. 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 significant sections of this year's proposed rule:

- **XIX. Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges**
- **X.A. Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)**

- **XIV. Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs**

Hospital Price Transparency

XIX. Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

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.[1] Unveiling the underlying price of health care services – referred to as the negotiated rate – alongside meaningful health care quality information would empower consumers and purchasers of health care with the data needed to actually make informed choices about where to receive care.[2] Pricing data – and eventually quality data – would also enable researchers to identify which health care markets generate low-value care in order to develop and deploy targeted policy solutions to increase competition, lower costs, and drive high-value care in our nation's health care system.[3] As a result, it is essential that CMS continue to strengthen the hospital price transparency rule to achieve meaningful price and quality transparency in the health care system.

Enforcement and Compliance

***Consumers First* supports CMS' proposal to require hospitals to encode a senior officials name into the machine-readable file (MRF) along with a strengthened attestation statement to help verify the accuracy and completeness of the hospital price transparency data. However, *Consumers First* urges CMS to take additional steps to improve enforcement and compliance with the federal hospital price transparency rule.**

In the CY2026 OPPS proposed rule, CMS proposes to require hospitals to encode the name of a chief executive officer, president, or senior official that is "designated to oversee the encoding of true, accurate and complete" pricing data in the machine-readable file. CMS notes including the name of a hospital senior official in a hospitals MRF is intended to "establish that the data was reviewed and verified by the hospital's leadership" and will "expedite [their] ability to quickly identify an individual at the hospital to obtain... further clarity regarding the" price transparency data.[4] Moreover, CMS proposes to require hospitals to include a more detailed attestation statement affirming the completeness and accuracy of their hospital pricing data, including clarification that for example, the hospital has "included all payer-specific negotiated charges..." in their MRF.[5]

Consumers First agrees that this proposal takes an important step forward to further strengthen compliance and accountability with federal price transparency regulations. Despite the Hospital Price Transparency rule being in effect since January 2021, the vast majority of hospitals fail to comply with the federal requirement to post the actual price of health care services. According to recent estimates, only 21.1% of our nation's hospitals are in compliance with the federal hospital price transparency rule and only 17% of hospitals posted their negotiated rates in *dollars and cents*.[6] Many hospitals have failed to post any negotiated rates at all. Others display incomplete information or post data in ways that are difficult for most people to understand, such as listing prices as a percentage of Medicare rates (i.e.

200% of Medicare).[7] The fact that thousands of U.S. hospitals are still out of compliance and would rather risk paying a $2 million per year fine instead of complying underscores that hospitals have a strong financial incentive to keep their prices hidden and that CMS' enforcement mechanisms for this rule are simply not strong enough.

Therefore, Consumer First recommends CMS build upon its initial proposal to require hospitals to encode a senior officials name in its MRF and in addition to requiring the senior official to sign such 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 hold hospitals accountable for the accuracy and completeness of the hospital pricing information in their MRF.

Moreover, to further ensure hospitals meaningfully comply with federal hospital price transparency requirements, ***Consumers First strongly* recommends CMS increase 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.

Requirements for posted prices

Consumers First continues to oppose CMS' proposal to allow hospitals to continue posting percentages and algorithms as well as other price estimates such as a "median allowed amount" in place of the dollars and cents negotiated rates of services. As a result, we urge CMS to require hospitals display all negotiated rates in dollars and cents without exception.

In the CY2026 OPPS proposed rule, CMS proposes to replace the "estimated allowed amount" data field finalized in CY2024 OPPS and instead require hospitals to post four new data elements in their machine-readable hospital pricing files when a negotiated rate is based off an algorithm or a percentage: the "median allowed amount," "10th percentile," "90th percentile," and "count of allowed amounts."[8] The "median allowed amount" is defined as the *median* price paid based on historical health care payments that hospital has received for up to 12 months prior to posting the MRF.[9]

Most importantly, the only data point that actually unveils the true price of health is the negotiated rate. Estimates, medians, averages and percentile are all pieces of information but without the actual negotiated rate, consumers and health care purchasers remain blind when shopping for care and negotiating for lower costs. 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 with the actual purchasers of health care.[10] Moreover, it is now well understood that negotiated rates are available through the Transparency in Coverage data files.[11] 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 date does, in fact, exist, and can be shared.[12] Now it is up to policymakers to ensure hospitals actually disclose those health care prices publicly without having to rely on inaccessible third party vendors to translate the data into meaningful pricing information.[13] **Therefore, *Consumers First* urges CMS to explicitly require hospitals**

to display all standard charges, and specifically the negotiated rate, *in dollars and cents,* and prohibit hospitals from posting 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.

Requirements for quality data

In order for there to be meaningful oversight of the health care industry, ultimately, both pricing information and information about the quality of care it provides should be publicly available to researchers, policymakers, and consumers. Requiring price and quality information to be displayed together would ensure that hospitals and industry players across the health care system compete based on fair and accurate information and would empower consumers and purchasers to make more informed decisions about their health care.

Therefore, *Consumers First* recommends CMS require hospitals, over time, to publish and pair quality information with pricing information. To do this, 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.

While we understand that additional work is needed to arrive at and report on a harmonized set of meaningful quality measures, 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.[14] At the same time, *Consumers First* does not want CMS to slow its efforts to improve hospital compliance with price transparency requirements while it waits for quality data to be more readily available. Any delay would undermine CMS' efforts to achieve meaningful price transparency in health care.

Comprehensive Site Neutral Payment Policy

Consumers First has long urged CMS to expand its site neutral payment policy to additional services and sites of service to end the longstanding distortion in Medicare reimbursement that creates the financial incentive for hospitals to push patients to higher cost care settings and to purchase independent doctor's office in order to generate a higher reimbursement from Medicare.[15] 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.[16]

Drug Administration

***Consumers First* strongly supports CMS' proposal to extend site neutral payments to drug administration services delivered by "grandfathered" off-campus provider-based departments, starting in CY2026.**

In the CY2026 OPPS proposed rule, CMS proposes to extend site neutral payments – that is the Medicare Physician Fee Schedule rate – to the delivery of drug administration services delivered by "grandfathered" off-campus provider-based departments that were previously exempted from site

neutral payments in the Bipartisan Budget Act of 2015, starting in CY2026.[17] Importantly, CMS proposes to extend site neutral payments to these new set of services and sites of service in a non-budget neutral manner, which CMS estimates will decrease total Medicare payments by $280 million and decrease beneficiary co-payments by $70 million, in 2026, alone.[18]

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 delivered to patients regardless of site of service and should be subject to site neutral payments.[19] This proposal is particularly important for those health care consumers that rely most heavily on physician administered drugs, such as chemotherapy patients.[20] Nearly one in four Americans with medical debt who had cancer declared bankruptcy or lost their homes and two-thirds have cut spending on essentials like food and clothing.[21] Enacting site neutral payments for drug administration would provide these patients much needed relief from high health care prices and save the highest-need chemotherapy patients more than $1,000 on cost sharing a year.[22] This proposal, if finalized, would also generate significant savings to Medicare and taxpayers; the Congressional Budget Office estimates a similar legislative proposal would produce $3.74 billion in government savings, over ten years.[23]

At the same time, ***Consumers First*** **recommends that CMS go further and expand site-neutral payments to additional services and sites of care. CMS should maximize the use of its regulatory authority in carrying out these recommendations, and, if needed, work with Congress to obtain additional authority. Specifically, we recommend:**

- **Eliminating the "grandfathering" of higher OPPS payment rates for existing off-campus provider-based departments for all services, not just clinic visits**. The Congressional Budget Office previously estimated that closing this loophole would save $13.9 billion between 2019 and 2028.[24]
- **Extending site-neutral payments for clinic visits to all on-campus provider-based departments.** MedPAC's 2017 report estimated that implementing site-neutral payments for clinic visits at on-campus and off-campus provider-based departments would save Medicare almost $2 billion per year.[25]
- **Extending site-neutral payments across a broader set of 66 clinical services including:**
    - **The 57 Ambulatory Payment Classifications (APCs) identified in the June 2022 MedPAC Report (and following reports) to Congress, to align the OPPS and alternate care site payment rates with those set in the MPFS;[26] 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 office.[27]**

Enacting comprehensive site neutral payment policies would result in significant savings for consumers and Medicare: In late 2024, the Congressional Budget Office estimated that a comprehensive site-neutral policy would save Medicare approximately $157 billion.[28] And the Committee for a Responsible Federal Budget estimated in 2023 that implementing a comprehensive site neutral payment policy for Medicare would reduce cost-sharing for Medicare beneficiaries by $94 billion.[29]

Sole Community Hospital Exemption

***Consumers First* opposes CMS' proposal to exempt all rural sole community hospitals (SCHs) from site neutral payments for drug administration services delivered by "grandfathered" off-campus provider-based departments and urges them not to finalize this proposal. Similarly, we urge CMS to revisit and reverse its policy that exempts rural sole community hospitals from site neutral payments for the delivery of clinic visits in "grandfathered" off-campus provider-based departments in the first place.**

In the CY2026 proposed OPPS rule, CMS proposes to exempt sole community hospitals located in rural areas from being paid site neutral payments – the MFPS rate – for the delivery of drug administration services.[30] This proposal builds on CMS' existing policy that exempts rural sole community hospitals from being paid the site neutral payment rate for clinic visits delivered in excepted off campus HOPDs.[31] Rural sole community hospitals are defined as hospitals located in non-metropolitan areas with less then 50,000 residents and 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.[32]

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 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.[33] Given 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.[34] Enacting site neutral payments is a key tool for promoting healthy competition in rural communities and lowering health care costs for rural families.[35] **As such, *Consumers First* urges CMS to enact site neutral payments without exception and across all geographic areas, to remove a key driver of hospital consolidation and unaffordable care that negatively impacts health care affordability in both rural and urban communities, alike.**

While *Consumers First* recognizes that certain rural and safety net providers may require targeted financial support to move into site-neutral payments to help sustain health care delivery and health care access for patients and families in rural and underserved areas, we believe that waiving site neutral policies for broad categories of hospitals without a very surgical approach risks undermining the goal of site neutral payments and the problem it is designed to solve. For example, 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.[36] Fundamentally, identifying hospitals in need based solely on their isolation from other hospitals runs the risk of the sole community hospital designation either including providers that predominately serve higher income communities that often have a significantly large share of patients with commercial insurance or those hospitals that are near monopolist systems and already charging irrational prices for life-saving hospital care.[37] 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 (that is margins) and yet operates two hospitals in Fairmont and Austin, MN that are identified as rural sole community hospitals.[38] Rural hospitals affiliated with large corporate health systems have a very different financial outlook and would be more able to absorb the financial impact of changes to site of service payment differentials than independent rural hospitals (those

hospitals not affiliated with large systems.).[39] Taken together, exempting all sole community hospitals risks allowing large rural 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.[40]

At the same time, exempting *some* rural hospitals, such as rural independent hospitals, or delaying implementation of site neutral payments for such hospitals, may in fact be a reasonable policy approach to implementing site neutral payments and mitigating any disproportionate impact on those rural hospitals that have greater financial uncertainty. **To that end, when considering any exemptions, Consumer First would urge CMS to take a more surgical approach and consider targeting exemptions for *only* independent rural hospitals – hospitals not affiliated with large corporate systems.**

Quality Reporting Programs

XIV. Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

The Hospital Outpatient Quality Reporting (OQR) Program is a quality data reporting program implemented by CMS for outpatient hospital services. Hospitals are required to report data using standardized measures of care to receive the full payment update to their OPPS payment rate.

In the CY2026 OPPS proposed rule, CMS proposed to remove the following quality measures from the Hospital OQR Program starting in the CY2025 reporting period, including:

1. *The Hospital Commitment to Health Equity (HCHE)* measure, a structural measures that seek to assess the extent to which hospital and facility leadership are committed to driving the delivery of equitable health care along the five key domains: equity as a strategic priority, data collection, data analysis, quality improvement, and leadership engagement;
2. *The Screening for Social Drivers of Health (SDOH-1)* measure, a process measure that seeks to assess the extent to which hospitals are screening for a select group of health-related social needs (HRSNs) including food insecurity, housing instability, utility difficulties, and interpersonal safety; and
3. *The Screen Positive Rate for Social Drivers of Health (SDOH-2)* measure, a process measure that requires hospitals to determine the percentage of patients who are screened for health-related social needs that have at least one health-related social need.[41]

Removing these critical health care quality measures directly undermines the ability of Medicare and the health care system more broadly to drive meaningful improvements in health care quality and health outcomes for Medicare beneficiaries and our nation's families and workers. Medicare should be a leader among other payers in holding hospitals accountable for health care costs *and* high quality, including the nonmedical factors that drive more than 80% of what makes Americans healthy. It is essential for the Medicare program – the payer that sets the benchmark for how most health care services are paid and delivered – to incorporate strong quality measures into hospital payment in order to drive high-value health care for Medicare beneficiaries and our nation's families, workers and purchasers.

As such, ***Consumers First*** **opposes CMS' proposal to remove the HCHE, SDOH-1, and SDOH-2 measures from the Outpatient Quality Reporting program. We strongly recommend that CMS retain these measures and the ability to collect data on the nonmedical drivers of health in order to hold hospitals accountable for health outcomes.**

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 2026, and for considering the above recommendations. Please contact Aaron Plotke, Associate Director for Healthcare Innovation at Families USA at aplotke@familiesusa.org for further information.

Sincerely,

Consumers First **Steering Committee**

American Benefits Council
Families USA
Purchaser Business Group on Health

Partner Organizations

ACA Consumer Advocacy
BLKHLTH
California Pan-Ethnic Health Network
Center for Elder Law & Justice, New York
Clear Health Care Advocacy
Colorado Consumer Health Initiative
Consumers for Affordable Healthcare, Maine
El Centro, Inc.
Georgia Watch
Health Care Voices
Kentucky Voices for Health
Kintegra Family Medicine
Serving At Risk Families Everywhere (SAFE)
Small Business Majority
Tennessee Health Care Campaign
Third Way

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