



January 20, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-1834-FC: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity to Apply for Available Slots

Administrator Oz,

The Arkansas Hospital Association (AHA) represents more than one hundred health care facilities and over 45,000 employees across the state, all dedicated to providing essential medical care and community services to the people of Arkansas. On behalf of our member hospitals, we appreciate the opportunity to comment on the final rule for the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems.

We remain deeply concerned that the finalized OPSS market basket update for CY 2026 is insufficient to keep pace with the real and sustained inflationary pressures facing hospitals. For Arkansas hospitals, the market basket increase is estimated at 2.54 percent. After applying statutory and policy adjustments, the net increase in OPSS payments for CY 2026 is projected to be just 1.37 percent. This effectively means hospitals will experience little to no real payment growth in the coming year. Notably, this net update is less than half of the year-over-year increase in the Medical Care Consumer Price Index (CPI) of 3.2 percent – continuing the growing disconnect between Medicare payment updates and the actual cost of delivering care. When payments fail to keep pace with medical inflation, hospitals are forced to absorb rising labor, supply, pharmaceutical, and compliance costs without adequate reimbursement, which threatens their long-term financial stability and access to outpatient services.

We appreciate CMS's decision to revisit the 340B drug payment provisions and reduce the recoupment rate and extend the recovery period. While we continue to affirm our position that the

claw-back itself is unlawful and inconsistent with the Medicare statute, we recognize CMS's willingness to listen to hospital concerns and moderate the immediate financial impact of the recoupment process.

We remain firmly opposed, however, to the proposed expansion of site-neutral payment policies to grandfather off-campus hospital outpatient departments (HOPDs) for 61 HCPCS codes related to drug administration. CMS's rationale that the physical administration of drugs is similar across sites of care fails to account for fundamentally different infrastructure, regulatory obligations, and cost structures hospitals must maintain. HOPDs operate under CMS Conditions of Participation, accreditation standards, EMTALA readiness, emergency preparedness requirements, and heightened staffing and pharmacy obligations that do not apply to free-standing physician clinics and other non-hospital sites of care. Hospitals also face substantially greater administrative and reporting requirements, including but not limited to participation in the Hospital Quality Reporting Program, detailed cost reporting, price transparency compliance, and frequent audits. Treating hospitals as equivalents to clinics for payment purposes ignores these realities and penalizes hospitals for meeting the very standards CMS requires.

We are also disappointed by the continued inequities perpetuated through the Area Wage Index (AWI), particularly for rural states such as Arkansas. Although CMS previously acknowledged these disparities through the Low Wage Index policy, the discontinuation of that policy in the FFY 2026 IPPS Final Rule will only widen the reimbursement gap between rural and urban hospitals. We strongly urge CMS to reconsider its AWI methodology following the removal of the Low Wage Index to prevent further erosion of rural hospital viability and workforce stability.

Additionally, we strongly oppose CMS's finalized policy to incorporate market-based Medicare Advantage negotiated rates into the calculation of MS-DRG relative weights. Requiring hospitals to report median payer-specific negotiated charges by MS-DRG from machine-readable files imposes a significant new administrative and compliance burden, introduces substantial audit and enforcement risk, and forces hospitals to repurpose price transparency data in ways for which it was never designed. More fundamentally, this policy represents a departure from cost-based payment principles toward a methodology driven by commercial market dynamics, which will inevitably create winners and losers across hospitals and regions without regard to actual resource intensity. Because MS-DRG relative weights are budget neutral, hospitals with greater negotiating leverage are likely to benefit, while rural, independent, and safety-net hospitals with limited market power face systematic disadvantage, regardless of the costs they incur to deliver care. Tying Medicare payment to negotiated MA rates further risks distorting hospital behavior in the commercial market, discouraging innovation or experimentation with alternative pricing models, and undermines the original intent of the price transparency requirements. Taken together, these effects threaten to exacerbate existing inequities, particularly for rural hospitals and those serving vulnerable populations. These changes weaken provider confidence that IPPS payments will accurately reflect the true costs of care.

Finally, we strongly oppose the removal of the Inpatient-Only (IPO) list as proposed in the CY2026 Final Rule. Procedures on the IPO list were designated as inpatient-only due to their clinical complexity, higher risk profiles, and the need for intensive post-operative monitoring that cannot be reliably replicated in the outpatient setting. Eliminating the IPO list creates an information gap for

patients and providers and increases the risk that patients may be inappropriately steered toward outpatient care based on cost pressures rather than clinical appropriateness. Maintaining the IPO list is crucial for preserving patient protections and ensuring informed site-of-care decisions.

Sincerely,

A handwritten signature in black ink, appearing to read "Bo Ryall". The signature is fluid and cursive, with the first name "Bo" and last name "Ryall" clearly distinguishable.

Bo Ryall
President & CEO
Arkansas Hospital Association
boryall@arkhospitals.org