



September 15, 2025

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

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

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 proposed Calendar Year 2026 updates to the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center Payment Systems (ASC); Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency.

Arkansas hospitals are already operating under immense financial strain. In 2024, over 40 percent of hospitals participating in the OPPS reported negative operating margins, highlighting a fragile system that cannot sustain additional financial pressures. This instability is expected to worsen due to changes to Medicaid and Medicare programs under the recently enacted One Big Beautiful Bill Act. According to the Kaiser Family Foundation, Arkansas stands to lose between \$600 million and \$1 billion annually in Medicaid funding under this legislation, with additional reductions likely in ancillary payments tied to uncompensated care ratios. The policies proposed in CMS-1834-P risk pushing many of our member hospitals, particularly rural sole-community providers, to a tipping point, threatening access to essential care for thousands of Arkansans. We strongly urge CMS to reconsider proposed changes and adopt policies that stabilize, rather than disrupt, health care delivery in Arkansas.

While our overarching position is to minimize the significant financial and clinical harm that the proposed rule would impose on Arkansas hospitals and their patients, we recognize that the rule encompasses both concerning and acceptable provisions. At the forefront of our concerns is the proposed expedited recoupment of 340B remedy funds. The accelerated timeline represents an

unnecessary burden for OPSS hospitals and deviates from the more measured approach proposed in CY 2025. This change would extract significant funds from hospitals while ignoring the fact that CMS's prior 340B policy was unlawful. We urge CMS to eliminate recoupment entirely.

Equally troubling is the proposed expansion of site-neutral payment policies. We strongly oppose this expansion and reject CMS's assertion that treating more clinically complex patients does not impact the risk and resources required to provide routine services. HOPDs bear substantially higher compliance, staffing, and administrative costs than free-standing clinics. Expanding site-neutral payments fails to account for these realities and risks undermining access to critical outpatient services, particularly in rural areas.

Additionally, we strongly oppose the proposed removal of the Inpatient-Only (IPO) list. The IPO list exists to protect patients from undergoing procedures in settings inappropriate for their clinical complexity and risk. Encouraging the migration of high-risk surgeries to the outpatient setting jeopardizes patient safety and quality of care. Our concerns are compounded by the inconsistent application of the two-midnight rule by Medicare Advantage plans, which creates administrative and financial challenges for hospitals while potentially placing patients at risk.

We also continue to question the practical utility of expanded hospital price transparency file requirements, which impose significant administrative burdens without clear, demonstrated benefits to patients. Algorithmic reporting, additional data elements, and attestation revisions risk confusion, legal exposure, and unnecessary workload, particularly for hospital leaders, without improving patient decision-making.

Despite these concerns, we support several provisions in the proposed rule that could meaningfully benefit hospitals and patients. We oppose the threshold packaging of drugs and radiopharmaceuticals, given the financial and operational burdens this policy places on hospitals. We support expanded non-opioid drug and device policies and the broadened use of skin substitutes. We also applaud CMS's efforts to streamline quality reporting, including the removal of two health equity measures, the COVID-19 vaccination measure, and the consolidation of two emergency department timeliness measures into a single eCQM, reducing administrative burden without compromising quality.

Finally, we provide perspective on new proposals where refinement is warranted, including reimbursement methodologies for software as a service products, mechanisms to control unnecessary growth in outpatient services, and reimbursement adjustments for services predominantly performed outside the hospital setting. In these areas, we encourage CMS to adopt approaches that support hospital sustainability, preserve patient safety, and incentivize innovation without adding undue administrative or financial burden.

Market Basket Update

The AHA is disappointed that the proposed CY 2026 market basket update once again fails to reflect the real inflationary pressures faced by hospitals. While CMS proposes a 2.53% update offset that appears favorable when compared to the national inflation rate of 2.3% in the southern region, this calculation does not capture the true costs borne by hospitals. Year-over-year inflation for medical care is up 4.3%, electricity has increased by 7.2%, and gas utility costs have risen

13.8%. These categories represent significant and unavoidable expenses for hospitals, particularly in rural areas where operating margins are already strained. The proposed adjustment, therefore, falls far short of covering actual cost growth, leaving hospitals in an increasingly unstable position. We urge CMS to adopt a market basket methodology that reflects a realistic cost increase to hospitals, rather than relying on broad metrics for inflationary impacts that mask the severity of cost increases in health care.

340 Remedy Proposal

From 2018 through 2022, CMS implemented an unlawful policy that reduced payments for certain providers under the 340B Drug Price Program from ASP plus 6 percent to ASP minus 22.5 percent. Because of budget neutrality requirements, this nearly 30 percent payment reduction was offset by a 3.19 percent increase in non-drug service payments to all hospitals paid under the OPSS. Following successful litigation led by the American Hospital Association, the Supreme Court unanimously ruled that CMS's policy was unlawful. In response, CMS finalized a remedy requiring \$10.6 billion in lump-sum repayments to affected 340B hospitals, while also seeking to recoup \$7.8 billion in offsetting payments from OPSS hospitals. The stated goal was to return hospitals to the position they would have occupied had the policy never been implemented. To achieve this, CMS finalized a recoupment methodology that would reduce the OPSS conversion factor by 0.5 percent annually beginning in CY 2026 and extending through CY 2041. While we affirm our overall opposition to any level of recoupment, we can at least agree that an extended recoupment process would result in the least amount of financial hardship on hospitals. We affirm the national American Hospital Association's position that the entire recoupment process is unlawful. It disregards the fact that it was CMS's own illegal policy that created this predicament and forces hospitals to bear the consequences of the agency's missteps.

The Arkansas Hospital Association urges CMS to eliminate the recoupment process altogether. Proceeding with recoupment ignores the reality that CMS and HHS subverted federal law when they reduced payments under the 340B program. While CMS has not taken responsibility for this action, the recoupment methodology outlined in the CY 2025 OPSS proposed rule at least reflects a reasonable approach. Though not insignificant, this approach provided hospitals with a stable, predictable adjustment and recognized the difficult position CMS placed them in.

The new proposal represents a dramatic and unnecessary escalation. CMS now proposes to increase the annual recoupment rate to 2 percent, beginning in CY 2026 and concluding in CY 2031. For Arkansas hospitals, this change would result in a loss of approximately \$13 million in CY 2026 alone. To put this in perspective, the projected CY 2026 market basket update for Arkansas hospitals is \$21 million, meaning 61 percent of that adjustment would be erased before any other policy changes are considered. Based on current estimates, at least eight hospitals in Arkansas would receive lower Medicare payments in CY 2026 than in CY 2025 solely because of this policy. This outcome undermines the very purpose of annual updates, which are intended to account for rising costs and preserve access to care. In addition, we are concerned about the proposed 340B Rebate Model Pilot Program, which would introduce significant administrative complexity for hospitals. The pilot program would require hospitals to effectively float the cost of 340B drugs until rebates are issued on the back end, creating cash flow challenges and increasing financial risk, particularly for smaller and rural hospitals. The potential for disputes and appeals further

compounds this burden, diverting scarce administrative resources away from patient care. Implementing the pilot in tandem with the proposed aggressive recoupment schedule will only exacerbate the financial pressure hospitals already face.

Furthermore, we are particularly troubled that CMS would even suggest increasing the recoupment rate even further, up to 5 percent annually, to accelerate the process. Such an approach would extract an additional \$20 million annually from Arkansas hospitals between CY 2026 and CY 2029. This punitive approach compounds the harm of the original unlawful policy and comes at a time when CMS has taken no comparable action against Medicare Advantage contractors who participated in the same illegal payment structure. We oppose the recoupment process in its entirety and express our deep disappointment that CMS continues to pursue this course of action in the face of the unprecedented financial and operational pressures hospitals are already enduring as a result of the One Big Beautiful Bill Act.

Site Neutral Expansion

In the CY 2026 OPPI proposed rule, CMS seeks to expand site-neutral reimbursement policies to hospital outpatient departments (HOPDs) that were previously grandfathered off-campus provider-based departments for 61 HCPCS codes related to drug administration. CMS justifies this expansion by suggesting that the physical administration of these procedures is similar whether performed in HOPDs or free-standing physician clinics. While the technical process of administering a drug may indeed be comparable across sites, this rationale overlooks the broader infrastructure, compliance requirements, and administrative obligations that make HOPDs fundamentally different from physician offices.

Hospitals operate under an extensive framework of federal requirements that clinics do not face. HOPDs must comply with CMS's Conditions of Participation, accreditation standards through entities such as The Joint Commission, and comprehensive emergency preparedness rules. They are also required to maintain readiness for EMTALA compliance and provide round-the-clock staffing, access to emergency equipment, pharmacy services, and higher staffing ratios. These requirements create a fundamentally different level of responsibility and cost structure than those of a free-standing clinic, which is generally subject only to state licensure requirements and participation in the Physician Fee Schedule.

The administrative and reporting requirements further underscore these differences. HOPDs must participate in the Hospital Quality Reporting Program, report on outpatient-specific quality measures, and contribute to broader hospital quality initiatives. They are also required to submit detailed hospital cost reports, maintain compliance with hospital price transparency regulations (expected to become more rigorous under this same proposed rule), and undergo frequent and extensive audits. By contrast, clinics typically report at the group level under the Merit-Based Incentive Payment System (MIPS) and face far fewer ongoing administrative requirements. The cumulative effect is that hospitals bear a much greater regulatory and administrative burden to provide outpatient services.

Given these realities, the proposed expansion of site-neutral payment policies fails to recognize the true costs hospitals incur to deliver care in HOPDs. Treating hospitals as equivalent to clinics in the

context of drug administration reimbursement diminishes the value of the infrastructure and obligations CMS itself has required hospitals to maintain. This approach not only penalizes hospitals for complying with federal standards but also risks reducing access to hospital-affiliated outpatient services, particularly in rural and underserved areas. Consequently, we can at least acknowledge the value of excluding rural sole community hospitals (SCHs).

For these reasons, the AHA opposes the proposed expansion of site-neutral payments for the 61 identified HCPCS codes. We urge CMS to suspend further expansion of site-neutral policies until it develops a comprehensive strategy to address the inconsistencies and inequities in administrative and compliance requirements between hospitals and physician clinics. Without such reforms, site-neutral requirements will continue to eat away at the financial stability of hospitals, discourage hospitals from integrating outpatient services, and ultimately hinder patient access to care.

Area Wage Index

The AHA is disappointed by the continued inequities perpetuated through the Area Wage Index (AWI) policy, particularly in rural states like Arkansas. Even CMS acknowledged these disparities when it implemented the Low Wage Index (LWI) policy to provide relief to hospitals. With the discontinuation of the LWI policy in the FFY 2026 IPPS Final Rule, the reimbursement divide between rural and urban states only grows deeper. For Arkansas hospitals, the proposed CY 2026 update results in a reduction of more than \$5 million compared to CY 2025, compounding existing financial pressures at a time when stability is needed.

What is particularly troubling is CMS's inconsistent approach to cost recognition across policies. In a previous section of this comment letter, we describe how CMS justified site-neutral payment expansions by asserting that services should not be reimbursed differently because of the setting in which they are delivered, despite the substantial differences in infrastructure, staffing, and compliance obligations borne by hospitals. Yet in the AWI, CMS continues to assign value based on geographic location, disregarding the fact that the cost of care in rural states is significant. This inconsistency undermines confidence in CMS's methodology and highlights the arbitrary nature of these policies.

We strongly urge CMS to reconsider its approach to the AWI following the removal of the low wage index policy. Without corrective action, rural hospitals in Arkansas will face yet another year of disadvantage that erodes their ability to recruit and retain staff, sustain services, and provide equitable care to their communities.

Patient Access and Clinical Care

Virtual Direct Supervision for Cardiac, Intensive Cardiac, and Pulmonary Rehabilitation

We support CMS's proposal to permanently revise the definition of direct supervision for cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation, and diagnostic services in hospital outpatient departments to include virtual direct supervision. This change will expand access to these specialized services, particularly in rural areas where programs are limited and staffing is a challenge. By moving this policy from temporary to permanent, CMS provides hospitals the certainty needed to maintain existing programs and encourages new adoption by rural providers

who may have been hesitant. In addition, allowing supervision through telehealth reduces the financial burden of maintaining on-site certified staff, making these services more affordable for hospitals to offer while improving patient access to critical therapies.

Payments for Drugs, Biologicals, and Radiopharmaceuticals

We recognize that CMS's threshold-packaging policy for drugs, biologicals, and radiopharmaceuticals may provide administrative efficiencies for the agency by standardizing reimbursement for items under \$140 per day. However, for hospitals, this approach introduces significant financial and operational challenges. The costs of drugs can vary widely, and when multiple low-cost drugs are used in outpatient procedures, the packaging threshold may result in substantial cumulative losses, particularly for hospitals with high procedure volumes. Hospitals must also determine whether each drug qualifies as threshold-packaged or policy-packaged, creating additional administrative burden and increasing the risk of billing errors, claim denials, or potential recoupments. For these reasons, we also oppose CMS's proposal to increase the packaging threshold for diagnostic radiopharmaceuticals from \$630 to \$655 per day. While CMS pays separately for radiopharmaceuticals above this threshold, the policy exposes hospitals to similar financial risk and administrative complexity as the \$140 threshold for other drugs. While the packaging policies may streamline reimbursement from CMS's perspective, they shift financial risk and operational burden onto hospitals, undermining their ability to reliably manage costs and provide patient care efficiently.

Inpatient Only List

The AHA opposes the removal of the Inpatient-Only (IPO) list as proposed in the CY 2026 OPSS rule. These procedures were designated as inpatient-only because of their clinical complexity, the risks associated with post-operative recovery, and the need for monitoring and support that cannot be replicated in an outpatient setting. Eliminating the IPO list creates an information gap between patients and providers, where patients may not fully understand the risks of outpatient surgery and could be inappropriately steered into lower-acuity settings by cost pressures or plan design. This concern is compounded by the inconsistent compliance of Medicare Advantage (MA) plans with the two-midnight rule, which already creates administrative and financial challenges for hospitals. Without the protections of the IPO list, patients may face reduced safety and quality of care. For these reasons, we strongly urge CMS to maintain the IPO list to preserve patient protections and ensure payment integrity.

Quality Reporting Program

The AHA supports CMS's proposal to remove the two health equity measures and the COVID-19 vaccination among health care personnel measure from the Hospital Outpatient Quality Reporting Program. Eliminating these measures will reduce administrative burden without diminishing the quality or integrity of reporting. We also support the proposal to retire the two existing emergency department timeliness measures and replace them with a single measure using the eCQM format.

Hospital Star Rating Methodology

The Hospital Quality Star Rating program has a significant impact on hospitals. Higher star ratings enhance a hospital's reputation in the community, influence patient decision-making, and can affect overall market share and patient volumes. At the same time, a reduction in star ratings can dissuade patients from seeking care at a facility, limiting access and creating financial strain. Beyond reputation, star ratings play a role in a hospital's ability to secure contracts with Medicare Advantage (MA) insurers, as plans frequently rely on these ratings to guide network inclusion. Star ratings also indirectly influence several Medicare programs, including the Hospital Value-Based Purchasing Program, the Hospital Readmission Reduction Program, and the Hospital-Acquired Condition Reduction Program. Taken together, changes in star ratings can shape not only patient choice but also hospital financial stability and long-term sustainability.

We oppose CMS's proposal to revise the methodology for the safety domain of the Hospital Quality Star Ratings by adopting a quantile-based approach. This methodology is not appropriate for assessing hospital safety because it does not measure performance against a fixed, meaningful standard. Instead, it only ranks hospitals relative to one another. Under such an approach, a hospital placed in the lowest quartile may still demonstrate strong safety outcomes but will be unfairly labeled as a low performer. Conversely, placement in the top quartile does not necessarily mean a hospital meets a high safety standard; rather, it simply indicates performance relative to peers. Tying such arbitrary and shifting measures to a program that affects patient access, market share, and insurer contracting creates uncertainty and penalizes hospitals unfairly.

The proposed methodology creates a particularly acute challenge for small and rural hospitals, which often lack the resources to invest in the same level of data analytics, staffing, and infrastructure as larger facilities. When CMS places special emphasis on a single program area such as safety, these hospitals may be forced to reallocate scarce dollars from other important quality domains, such as mortality reduction, readmission prevention, patient experience initiatives, and timely/effective care. The proposed methodology not only skews priorities but also risks degrading performance in other critical areas that matter to patients and communities.

We urge CMS to reject this approach and instead establish clear, evidence-based benchmarks that allow hospitals to measure progress against defined standards of care. Hospitals need meaningful, stable targets to drive safety improvements – not moving goalposts that obscure actual performance.

Hospital Transparency

Our hospitals remain committed to advancing price transparency and share the Administration's goal of providing patients with clearer, more actionable cost information. While certain provisions of the transparency rule may be useful, CMS should focus on policies that directly improve patient understanding of costs, rather than layering on additional administrative requirements that increase burden without meaningful benefit. For this reason, we oppose the addition of four new data elements, two general data elements, and the expanded attestation statement. Moreover, because hospitals often cannot precisely predict final reimbursement amounts due to insurer-

specific contract terms, the responsibility for providing patients with accurate, individualized cost estimates is more appropriately placed on payers. CMS should place a greater emphasis on requiring insurers to work with their members to understand the potential costs of pursuing treatment, as they are best positioned to calculate patient-specific out-of-pocket obligations.

The purpose of the hospital price transparency program is to equip patients with the knowledge needed to make economical care decisions. However, we question whether the proposed additions serve that purpose. Algorithmic metrics, such as the inclusion of 10th, 90th, and median values, are unlikely to enhance patient understanding of hospital pricing and could be misleading. The inclusion of a count variable is especially concerning. In cases where there is only one observation, this disclosure could expose negotiated rates between hospitals and insurers, undermining sensitive contracting arrangements. Even without the count, the proposed percentile reporting could indirectly reveal instances where only one observation exists, creating significant legal and competitive concerns. Rather than simplifying patient access to pricing data, these requirements risk creating additional confusion among patients.

We are also deeply concerned with CMS's proposal to revise the attestation requirement. The agency would require hospitals to affirm that they have provided "all necessary information" for the public to derive service prices, replacing the existing "good faith effort" standard. This shift fails to account for the inherent complexity of hospital billing, which relies heavily on insurer calculations and variables beyond the hospital's control. Hospitals cannot realistically attest that third parties could derive final service prices based on incomplete or insurer-dependent data. We strongly urge CMS to retain the current "good faith effort" attestation, which appropriately reflects what hospitals can provide. Additionally, requiring a CEO or senior executive to sign the attestation would be unnecessarily burdensome and counterproductive. Hospital leaders already carry significant responsibilities, and requiring their signature adds no meaningful value. Instead, CMS should trust the accuracy of attestations provided by qualified hospital staff who are directly engaged in the development and verification of these files. For these reasons, we urge CMS not to finalize these proposed changes.

Request For Information: Software as a Service Reimbursement

We commend CMS for its forward-looking approach in requesting information on the development of a reimbursement methodology for Software as a Service (SaaS). This proposal reflects a recognition of the growing importance of technology in modern health care delivery and the need to ensure hospitals have the financial support to adopt and sustain these solutions. As health systems continue to integrate digital tools into clinical and operational workflows, SaaS platforms have become critical for improving patient safety, enhancing care coordination, and streamlining administrative processes.

Reimbursement Considerations:

As health care delivery increasingly relies on digital solutions, CMS must adopt a reimbursement framework that accurately reflects the cost and value of SaaS offerings. Most SaaS platforms operate under subscription-based pricing rather than one-time purchases, often using tiered pricing models that result in stepped cost increases as hospitals scale to meet additional

performance, security, and compliance requirements. CMS should incorporate these realities into its reimbursement methodology, recognizing that these step-ups create significant cost jumps for hospitals.

We recommend that CMS adopt a service-based ambulatory payment classification (APC) model for SaaS reimbursement. Each SaaS should be assigned its own service-level APC to reflect the ongoing costs of providing, maintaining, and upgrading the software over time. For SaaS that directly supports a clinical procedure, its cost should be packaged into the relevant APC; for SaaS used independently, CMS should establish a per-unit reimbursement rate aligned with the estimated cost of the subscription. Default packaging should be avoided unless the SaaS tool is clearly incidental and of low value, such as widely used commoditized utilities. For innovative or transformative SaaS solutions, CMS should allow hospitals to justify reimbursement above any baseline threshold, thereby encouraging adoption of tools that can significantly improve patient outcomes, safety, or efficiency.

CMS should take an active role in supporting equitable access to SaaS by negotiating shared-service pricing models with vendors, leveraging its influence to secure reduced pricing for hospitals of all sizes. Without such intervention, rural and independent hospitals, which often lack enterprise-level discounts, face disproportionately higher per-unit costs. Similarly, CMS should include not only subscription fees but also fixed costs such as implementation, renewal, enhancement, and required integration fees when calculating appropriate reimbursement rates. Any new reporting or compliance obligations related to SaaS should be offset through additional funding or add-on payments, as hospitals should not be financially penalized for meeting federal reporting requirements.

Finally, CMS should design its reimbursement methodology to encourage competitive pricing and prevent market distortion. By creating a reimbursement framework that rewards value and outcomes rather than lowest-cost options, CMS can help ensure that hospitals have access to sustainable, high-quality SaaS tools without incentivizing predatory pricing practices.

Quality and Efficacy Considerations:

To ensure that reimbursed SaaS solutions provide measurable benefit, CMS should develop a structured process for assessing quality and efficacy. Hospitals should be encouraged to submit peer-reviewed studies, clinical trial results, and case studies demonstrating the solution's impact on patient outcomes, provider efficiency, and safety. CMS should then assign the SaaS solution to an appropriate APC and determine a reimbursement rate that reflects its demonstrated value.

As part of this evaluation, CMS should consider whether the SaaS improves provider workflow without introducing new risks, delays, or administrative burdens. Integration with existing EHRs, billing platforms, and health information exchanges should also be assessed, as seamless interoperability is critical to achieving efficiency gains. To promote vendor neutrality and avoid lock-in, CMS should require that reimbursable SaaS solutions comply with widely accepted interoperability and data transmission standards, including FHIR and HL7.

Importantly, CMS should adopt a pragmatic evidence approach that allows for provisional reimbursement of emerging SaaS technologies with strong potential to improve care delivery, even

when long-term data is still developing. This approach would enable hospitals to pilot innovative solutions while CMS collects real-world data to support continued reimbursement decisions.

CMS as a Partner in Reducing Burden:

Hospitals face growing regulatory and administrative demands. CMS has an opportunity to act as a true partner by designing a reimbursement model that minimizes duplicative reporting, streamlines data submission processes, and offsets costs associated with compliance. By doing so, CMS would not only support hospital adoption of high-value SaaS but also further its own goal of improving care quality, equity, and efficiency.

Conclusion

We strongly urge CMS to reconsider several provisions in the CY 2026 OPPS proposed rule that would impose significant financial and operational burdens on Arkansas hospitals. The proposed rule presents a level of financial strain far exceeding typical annual updates, threatening the stability of hospitals already operating under significant fiscal pressures. Most significantly, we urge CMS to eliminate the two percent 340B remedy recoupment, halt the expansion of procedures subject to site-neutral payment policies, and maintain the IPO list to preserve patient safety and clinical integrity. We also oppose the threshold packaging of drugs and radiopharmaceuticals, the expansion of hospital price transparency attestation requirements, and any additional administrative burdens that do not directly benefit patients. While we support measures that reduce reporting burdens, expand virtual supervision for cardiac and pulmonary rehabilitation, and encourage meaningful quality reporting refinements, the rule as proposed would exacerbate financial pressures, undermine patient access, and compromise the ability of hospitals to sustain essential services. We urge CMS to adopt a balanced approach that prioritizes hospital sustainability, safeguards patient care, and recognizes the true costs of delivering high-quality health care.

Sincerely,



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