September 15, 2025

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1832-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Submitted via regulations.gov.

RE: "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,

United States of Care (USofCare) is pleased to submit comments in response to the Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center proposed rule issued by the Centers for Medicare & Medicaid Services (CMS).

USofCare is a nonpartisan, nonprofit organization working to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. Importantly, we are committed to improving the health of everyday people and are eager to engage in solutions that do just that. We advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in the states and listening to people's experiences with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the federal level.

Our listening work demonstrates that people's top concern with the health care system is affordability. The United States spends considerably more on health care than peer nations despite no improvement in outcomes, saddling everyday people and families with the high cost of care. Regardless of partisan affiliation, 75% of people rate the cost of health care in the U.S. as "only fair" or "poor." Moreover, half of Americans report skipping or delaying care due to cost. Prices are rising in large part because of a decades-long movement toward consolidation led by corporate hospital and health care actors. **With this in mind, USofCare focuses our comments in response to the 2026 OPPS around the following themes:**

I. Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services
II. Payment for Skin Substitute Products Under the OPPS
III. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges
IV. Proposals and Requests for Information Related to Measures for Quality Reporting Programs

Expanding the Method to Control Unnecessary Increases in the Volume of Outpatient Services

A major driver of high costs in hospital care – and the health system as a whole – stems from payment differentials between care settings. Under their respective payment systems, Medicare

pays outpatient health facilities, including hospital outpatient departments (HOPDs) higher rates than physician offices for delivery of the same service. This discrepancy incentivizes hospitals to move patients into higher-cost settings in order to receive a higher payment rate. The payment rate under the OPPS is often 200-300% of the rate paid for the same services in physician offices – shifting additional costs onto beneficiaries and the Medicare program as a whole.

We share CMS's concern about the increase in the volume of drug administration services furnished in the HOPD setting, and similarly believe that the payment differential between the OPPS and the PFS for the same service are driving these volume increases. This practice also encourages consolidation in health care markets through hospital acquisition of physician practices, driving up health care prices for patients in the process. Our listening work has shed light on the impact this has on patients.

> *"My son went through that [confusion around hospital consolidation and its impact on health insurance claims/costs] when they changed everything. It was very chaotic because you got to figure it out. It's a frightening feeling because you feel like you're just being tossed whatever way they want to toss you for the whole money racket. Whatever works for them, that's what they're going to do, never mind the smaller person."*
> *- Black woman, North Carolina*

Most concerningly, these payment differentials between sites of service increase out-of-pocket costs for Medicare beneficiaries through higher cost sharing. The policy in this proposed rule would save Medicare beneficiaries $70 million in reduced coinsurance costs and the Medicare program $210 million for CY 2026 alone. Equalizing the OPPS drug administration rate with that of the PFS promotes financial stability for consumers and the Medicare Trust Fund at large. **Because of this, USofCare strongly supports CMS's proposal to apply the PFS equivalent rate for drug administration services provided at an off-campus provider-based department.**

We are also encouraged by CMS's request for information related to expanding this proposed policy to additional services under the OPPS in future rulemaking. There is evidence indicating that billing for a number of different services has shifted from the PFS to the OPPS, resulting in increases in utilization of higher-cost settings. Similarly, MedPAC, the body of Medicare experts that evaluates and makes recommendations to Congress regarding the Medicare program, has also signaled the misalignment in payment rates when it comes to charges for care across dozens of services delivered at off-site locations. **In addition to finalizing the site neutral proposal related to drug administration codes, we strongly urge CMS to apply site neutral payment rates in future rulemakings to additional services that can be safely performed in outpatient settings with a particular consideration of the 66 services identified by MedPAC.**

In addition to supporting efforts at the federal level to implement site neutral payments in the Medicare program, USofCare has undertaken extensive work in states to advance site neutral payments in commercial insurance at the state level. To that end, USofCare partnered with the Brown University Center for Advancing Health Policy Through Research (CAHPR) to release a report to understand cost savings associated with implementing three state policy options designed to lower health care costs for people and state budgets, including site-neutral payment

reform. This analysis found that if site-neutral policies were enacted in the commercial market in Massachusetts, Indiana, and North Carolina in 2022, consumers could have saved $2.7 billion in those three states alone. In addition to identifying billions of dollars of savings for consumers from site neutrality, the report also found that these reforms would have minimal effects on hospital finances.

Payment for Skin Substitute Products Under the OPPS

Despite mixed evidence on their effectiveness, there has been an influx of skin substitute products onto the market. Medicare spending on such products has grown exponentially, reaching over $10 billion in 2024 – nearly double that of the year before, in part due to payment structures that incentivize high prices as well as the use of the highest cost products, even if it is not the most clinically-appropriate product or treatment for beneficiaries. We share CMS's concern about the overuse of skin substitute products and how it will not only impact the long-term viability of the Medicare Trust Fund, but also to the health outcomes of beneficiaries. **Because of this, USofCare is supportive of CMS's proposal to separately pay for skin substitute products as supplies and establish a standardized rate payment for these products of $125 per square centimeter.**

While we agree that addressing Medicare overpayments for skin substitutes is an important step in curbing fraud, waste, and abuse – as well as beneficiary harm – associated with skin substitutes, **we also believe it is important that the Local Coverage Determination for these products becomes effective as soon as possible.** It is critical for CMS to ensure that Medicare coverage is only being provided to products that meet the statutory standard for coverage, as demonstrated through peer-reviewed, published evidence supporting their use. We believe that, in combination, these two policies will ensure that patients maintain access to proven effective skin substitutes while reducing Medicare spending on unproven, unnecessary, and costly products.

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

In tandem with our work to improve health care affordability, USofCare has ardently advocated for policy proposals to increase hospital price transparency for consumers. Our national polling indicates that patients – regardless of their political affiliation or background – overwhelmingly support policies that would make health care pricing more transparent up front. We know that people struggle to navigate an increasingly complex health care system in addition to their worries about being able to afford care altogether and this type of confusion can fuel people's mistrust in the health care system. States across the country have established meaningful hospital price transparency requirements that have empowered people to make informed decisions about their health care for themselves and their families. Robust hospital price transparency requirements on the federal level will further reduce consumer confusion around the price tag that may prevent them from accessing needed care or accruing medical debt.

> *"One of the challenges is figuring out whether the price you're paying is fair. Hospitals all have different prices, and if you have insurance, like here in Raleigh, you might find that one hospital offers a better price, but it could be out-of-network, which would make it unaffordable again."*
> *- Black woman, North Carolina*

In that vein, **USofCare appreciates the proposals within the 2026 OPPS that aim to improve the accuracy and usability of the pricing data that hospitals must report,** including the four new data requirements for when a standard charge is based on a percentage or algorithm (median allowed amount, the 10th percentile and 90th percentile allowed amounts, and the count of allowed amounts used to calculate the aforementioned percentile allowed amounts) and the requirement to include within a hospital's machine-readable file (MRF) the name of a senior-level official who can attest to the accuracy and validity of the data, including payer-specific negotiated charges in dollar amounts. We also support the proposal that would require hospitals to include their Type 2 National Provider Identifier within their MRF, which would make it easier to compare standard charge data across MRFs. The addition of these new data elements will help consumers access more accurate, understandable hospital price transparency data, in addition to bolstering accountability for hospitals.

As CMS considers additional ways to empower people with health care price transparency, **we encourage CMS to build upon its existing efforts by considering proven strategies already in effect on the state level** to further deliver on CMS' goals of providing accessible, affordable care. Given that many hospitals still fail to adhere to federal price transparency requirements, Arkansas and Texas have established enhanced state-level penalties for non-compliant hospitals. Colorado has emphasized hospital accountability by prohibiting non-compliant hospitals from collecting medical debt from people. Florida's law expands price transparency requirements to ambulatory surgical centers and Nevada's law pairs hospital price transparency requirements with facility fee reporting to give people a more complete picture of hospital and health system costs. Taken together, these state-driven, proven solutions can strengthen existing and proposed CMS actions to promote price transparency in hospitals and other health care settings.

Proposals and Requests for Information Related to Measures for Quality Reporting Programs

We appreciate CMS's interest in furthering the Administration's goal of improving health and health outcomes, as well as improving the prevention and management of chronic disease by integrating well-being and nutrition measures into the Hospital Outpatient Quality Reporting, Rural Emergency Hospital Quality Reporting, and the Ambulatory Surgical Center Quality Reporting Programs. As CMS considers and develops measures for use in these programs, USofCare urges the agency to ensure a person-centered focus with measures that have value for patients.

Additionally, our listening work has demonstrated that people overwhelmingly recognize that the current U.S. health care system is not fair and that not everyone can access the quality, affordable care they need due to their identity, background, income, social need, or where they live. We know that challenges in accessing care, such as cost, a lack of insurance coverage, long travel times and other transportation issues, and other factors, can have negative impacts on people's health. As such, we are disappointed that CMS is proposing to remove measures related to health equity and social drivers of health from its quality reporting programs. **We appreciate that CMS is exploring ways to reduce administrative burden for hospitals and providers; however, we believe that prioritizing the collection of data that can help drive reductions in health disparities outweigh the burden, and we urge the agency to reconsider removing these measures.**

Conclusion
Thank you for the opportunity to respond to the proposed rule. Please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org with any questions.

Sincerely,

Lisa Hunter
Senior Director for Federal Policy & Advocacy
United States of Care