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August 31, 2026

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

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots (CMS-1850-P)

Dear Administrator Oz:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed CY 2026 rule related to the Medicare Program Hospital Outpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, general medical surgical hospitals and large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

CMS's Proposed Payment Update Will Result in Year-Over-Year Medicare Losses for WI Hospitals

In this rule, CMS proposes a net increase of 2.4% for CY 2027, after a market-basket increase of 3.2% minus the ACA-mandated productivity adjustment of -0.8%. Unfortunately, this only continues CMS's recent trend of payment policies that do not acknowledge the true level of inflation and cost increases impacting health care and the country as a whole. It fails to account for the persistent labor, supply and drug costs the hospital field has experienced in the last three years and continues to face. ***While this would be challenging enough under normal circumstances, taken together with the unprecedented cuts to 340B reimbursements, it will result in an estimated net loss of more than $32 million for WI hospitals compared to the previous year. This does not even take into account the natural losses from continued demographic changes that will lead to more Wisconsinites leaving commercial insurance and joining Medicare, discussed in more detail below.***

A March 2026 report by the American Hospital Association highlights some of the cost increases hospitals are bearing right now. In 2025 alone, overall hospital expenses grew 7.5%, more than double the rate of hospital price growth. Workforce costs — nearly 60% of total hospital spending — rose 5.6% as hospitals worked to maintain adequate staffing across nursing, physician, and technical roles. At the same time, supply costs

increased 9.9%, and drug expenses climbed 13.6%, far outpacing general inflation and putting additional strain on already-tight budgets.

Hospitals are also caring for more patients with more severe and complex health needs. Between 2019 and 2024, 36% of expense growth stemmed from treating a greater number of patients, while 19% resulted from the increased staffing, monitoring, and specialized treatments required for higher-acuity individuals. These trends reflect the rising complexity of care hospitals must provide around the clock.

Compounding these pressures is the growing administrative burden tied to insurer practices. In 2025, hospitals nationwide spent $43 billion simply to secure payment for care already delivered — navigating prior authorization barriers, claim denials, repeated documentation requests, and evolving billing rules. These hurdles divert clinicians and staff away from direct patient care and add significant cost to the system. At the same time, a majority of hospital service lines — including behavioral health, obstetrics, infectious disease, and burn and wound care — are reimbursed below the actual cost of providing care. Approximately 56% of hospital costs fall into these under-reimbursed areas, many of which represent essential services available only in hospital settings. This underscores Wisconsin hospitals' commitment to maintaining access even when payment does not reflect the true cost of care.

The underpayments from Medicare have been driving these recent challenges. In Wisconsin, hospitals are paid only about 74% of what it costs to provide care to Medicare patients according to that same fiscal survey. And because Wisconsin is an aging state, it is seeing a large shift in people moving off private insurance and onto Medicare. From 2016 to 2024, the average payor mix for a Wisconsin hospital has seen Medicare grow from 43% to 49%, while commercially insured patients have shrunk from 37% of the payor mix to only 32% concurrently, according to claims data analyzed by WHA's Information Center. In fact, as of 2024, Wisconsin was tied for 8th among states with the highest percentage of their population covered by Medicare, at 22%. Due to this, **annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.6 billion in 2024, more than doubling in 8 years.** This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age.

Despite numerous financial pressures, hospitals have worked hard in recent years to keep costs down. National data show hospital expenses increasing far faster than hospital prices. In 2025, total hospital **expenses grew 7.5%,** compared to hospital price growth of just 3.3%, with supply costs rising 9.9% and drug expenses increasing 13.6%.

With these historic fiscal challenges facing hospitals, **we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

Proposed 340B Accelerated Claw Back Exemplifies the Unpredictable Environment Hospitals Operate In

One often hears the old adage that government should operate more like a business, and that government must understand the needs of businesses. Unfortunately, hospitals increasingly find themselves cast in a no-win situation where they are, on the one hand, expected to operate like a business and maximize efficiency. On the other hand, there is increasing scrutiny of hospital mergers or the closure of service lines. Hospitals necessarily operate in this environment where they strive to meet the community needs but also must understand the reality that continuing to operate money-losing service lines will threaten the very viability of the hospital itself. It was only a few years ago that two long-standing hospitals in Wisconsin's Chippewa Valley faced this reality; their closures continue to impact the surrounding communities, though neighboring hospitals have stepped in to meet patients' needs as best they can.

In this rule, CMS announces it is going forward with the accelerated recoupment of hospital payments that went out due to the previously-ruled unlawful 340B cuts being applied in a budget neutral manner. The agency had previously finalized a recoupment strategy recouping the full $7.8B in payments from 2026-2042; the new timeline would fully recoup these payments by the end of CY 2029, leading to a cut of $2.3 billion for all PPS hospitals in 2027. ***CMS should abandon this accelerated recoupment proposal once and for all, as it exemplifies the unpredictable environment hospitals must operate in.***

CMS has already taken public comment on and finalized its previous proposal to spread the recoupment across a much longer time-period, now changing course after hospitals based budgetary decisions on this decision. The longer glide-path minimizes the impact on hospitals that are already plagued with Medicare payment rates that are not keeping up with the true cost of inflation. Hospitals must plan out their budgets based on expectations around existing payment guidelines and often must consider future plans for opening new facilities, purchasing new medical equipment, raising pay rates to recruit and retain staff, and expanding in-demand service lines like obstetrics, labor and delivery and behavioral health that often lose hospitals money.

CMS was ordered by the United States Supreme Court, in a unanimous decision, to repay 340B hospitals due to its own illegal actions to reduce payments to 340B hospitals in the first place. As WHA has previously argued, CMS should not be asking hospitals to bail it out for its own unlawful actions, and it is uncertain as to whether CMS even has the authority to retroactively apply budget neutrality requirements in this manner.

340B Reimbursement Cuts Undermine the Intent of the Program

As we have previously done, WHA continues to raise concerns with the proposal to cut 340B reimbursements by nearly 40%, from the average sales price (ASP) plus 6% to ASP minus 33.4%. This is another example of the constantly shifting policies coming out of CMS that lead to uncertainty. Even worse, this policy undermines the very intent of the 340B program created by Congress, which is to "enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." How can hospitals stretch scarce resources if the federal government, which already reimburses Wisconsin hospitals only about 74% of what it costs them to provide care to Medicare patients, is using this provision to further erode 340B hospital financial resources?

CMS has undertaken this action after having previously attempting to do so in an unlawful manner in the 2018 OPPS rule and then being ordered to repay hospitals by the U.S. Supreme Court. Due to the previous errors CMS made, hospitals are now facing an erratic recoupment strategy that is making it even harder to plan and budget for the future. Now, CMS has come back with purported results of a new survey that it is utilizing to make an even larger cut than initially proposed in the 2018 OPPS rule. However, there continues to be questions about CMS's sample and statistical methodology that warrant further scrutiny. Instead, CMS is pushing ahead with those proposed cuts despite these valid concerns.

As discussed in the payment update section of this comment letter, Wisconsin hospitals are facing significant headwinds due to CMS's continued inadequate payment increases that do not account for the true costs of inflation or the demographic changes leading to more patients leaving commercial insurance and joining Medicare. WHA fully supports efforts by CMS to provide additional funding to hospitals to account for these headwinds. However, this should not be done at the expense of a particular group of hospitals, especially, those that serve the highest acuity patients and largest percentage of low-income Medicaid patients. At the very least, a proposal of this magnitude to alter a program created by Congress should not be done unilaterally by a federal agency without first going through Congress. ***Instead of proposing policies that reduce reimbursements for 340B or other hospital types, CMS should update its inflationary payment methodology in a way that aids all hospitals facing Medicare losses.***

These proposed cuts are projected to decrease prescription drug reimbursements by an estimated $138 million for Wisconsin's 340B hospitals. While we acknowledge that some hospitals will benefit in the form of

budget neutral conversion increase for non-drug services, 340B hospitals that stand to lose the most from this policy treat some of the state's highest-acuity patients. It's important to remember that, by definition, the 340B hospitals impacted by this rule must also serve a high proportion of Medicaid and low-income Medicare patients. Effectively, that means CMS's proposal will amount to a transfer of Medicare funds away from hospitals that serve the highest proportion of Medicaid and low-income Medicare patients.

CMS should not proceed with these cuts to 340B hospitals that undermine the very purpose of the 340B program's mission of allowing hospitals to stretch scarce resources and serve more patients.

Continued Elimination of the Hospital Inpatient-Only List

WHA remains concerned about CMS's continued implementation of the policy to eliminate the Hospital Inpatient-Only (IPO) list. While WHA supports efforts to reduce unnecessary regulatory requirements and recognizes that advances in technology and clinical practice have enabled certain procedures to be safely furnished in outpatient settings, we continue to have concerns regarding the potential impact on patient safety and access to appropriate post-acute care services.

Many procedures historically included on the IPO list involve medically complex patients who may require extended monitoring, multidisciplinary care coordination, and access to inpatient resources should complications arise. As additional procedures are removed from the IPO list, CMS should closely monitor patient outcomes, including complications, readmissions, emergency department visits, and other indicators of care quality to ensure patients continue to receive care in the most appropriate setting.

WHA also remains concerned about the interaction between the elimination of the IPO list and Medicare's skilled nursing facility three-day inpatient stay requirement. As long as the three-day inpatient stay requirement remains in place, beneficiaries who undergo procedures that were historically performed on an inpatient basis may no longer qualify for Medicare-covered skilled nursing facility services despite having similar post-acute care needs. WHA continues to support elimination of the three-day stay requirement and encourages CMS to consider the unintended consequences that continued removal of procedures from the IPO list may have on Medicare beneficiaries' access to needed post-acute care.

CMS Should not Move Forward with Site-Neutral Payments

WHA opposes the proposal to begin paying previously grandfathered off-campus hospital outpatient departments at the "site-neutral" physician clinic rate for certain imaging services. Moving forward with this proposal would lead to an estimated $3.4 million cut to Wisconsin hospitals in 2027 alone, on top of the $138 million in 340B reimbursement cuts.

As previously noted, it is a well-known fact that *Medicare already underpays hospitals.* Based on WHA analysis of required annual hospital reports, Wisconsin hospitals are paid about 74% of what it costs them to care for Medicare patients, contributing to annual underpayments exceeding $3.3 billion.

This proposal fails to recognize that long-standing Medicare payment policy was designed to pay higher rates at hospital outpatient departments (HOPDs) because they are an extension of hospitals that have been shown to treat sicker, more vulnerable patients. The higher payments also recognize that the hospitals they support:

- Provide emergency room and inpatient (and often intensive care unit) care 24/7/365.
- Provide more specialized care for patients with higher acuity needs.
- Serve patients regardless of their ability to pay, including a higher mix of Medicaid/Medicare patients.

CMS has also previously recognized that Medicare payment rates reflect the higher costs associated with delivering services in an HOPD:

"When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively."[i]

It is also concerning that CMS is citing authority for these cuts, "to control unnecessary increases in the Volume of outpatient services," that appears to be in direct conflict with the Bipartisan Budget Act of 2015 and 21st Century Cures Act, which intentionally grandfathered existing on-campus and off-campus HOPDs at the current higher payment rate. While CMS prevailed against a court challenge to prior usage of this authority, the case was decided in CMS's favor only after an appeals court cited the Chevron doctrine of agency deference that has now been called into question as a result of the 2024 Loper Bright decision.

CMS's Proposal for Provider-Based Attestation is Unnecessarily Burdensome

This rule implements provisions from the Consolidated Appropriations Act (CAA) of 2026 which specify that grandfathered off-campus hospital outpatient departments must bill Medicare using a separate national provider identifier (NPI) and an attestation that the off-campus HOPD meets the requirement of federal provider-based rules. CMS proposes to require initial attestations for these sites to be submitted prior to December 31, 2027, and at least every five years thereafter. Locations that have received a provider-based determination before Jan. 1, 2026, would need to submit some evidence that they have previously received a provider-based determination as well as evidence of continued compliance, but would not need to submit separate attestation.

CMS is proposing to replace the Medicare Administrative Contractor (MAC)-specific attestation templates with a centralized electronic system. Each provider must also obtain a unique NPI for each of their off-campus PBDs prior to the electronic system going live. Whereas the current process utilizes a review from MACs which forward their recommendations to CMS for the initial determination, the new process would have CMS specify a standardized review and validation process for MACs to utilize which may include automated validation activities, data analysis, targeted documentation, and contractor review procedures. Ultimately, the MAC would decide whether it believes the site meets the requirements laid out by CMS and providers would be required to maintain documentation demonstrating compliance with provider-based requirements.

The attestation form would be required to contain the following elements:

- Identify the main provider and each off-campus HOPD.
- Documentation measuring the distance requirement.
- Documentation demonstrating the off-campus department is operated under the same licensure as the main provider.
- Documentation that patients treated at the off-campus department have access to the same services and providers as the main provider.
- Documentation that revenues and expenses of the off-campus department are integrated with those of the main provider.
- Documentation that the off-campus department is clearly identified to the public as a part of the main provider.

- Compliance with EMTALA, site-of-service billing requirements, and written notice of financial liability for Medicare patients.
- Documentation that the off-campus provider operates under the ownership and control of the main provider.

CMS would create a 3-tiered system of review for initial compliance, targeted review for attestations that present indicators of incompleteness, and extended review for those that present the highest risk of non-compliance.

WHA is supportive of CMS's proposal allowing previously submitted attestations of compliance for an off-campus department, regardless of whether a determination by CMS has been made by that date. This will help reduce unnecessary burden on providers and the department. WHA also supports CMS's efforts to standardize the electronic application process and allow MACs to review attestations without requiring separate CMS review, so long as they operate with clear guidance that minimizes variations among MACs. WHA has been made aware of prior instances where different MACs have enforced their interpretations of the same CMS rule or federal statute differently, which has created unnecessary burden for Wisconsin providers.
WHA is further concerned that the overall attestation process and use of separate NPIs will be overly burdensome for hospitals with off-campus provider-based locations. WHA previously cautioned lawmakers that the requirement to obtain a separate NPI was unnecessary, because Medicare billing already gave CMS the ability to determine which claims were for an off-campus HOPD. While WHA understands CMS is implementing the statute required by the CAA of 2026, we are concerned that the new process has extensive requirements that will not add the intended transparency that was the goal of the CAA of 2026.

WHA appreciated the *Patients Over Paperwork* initiative announced by CMS during the first Trump Administration in 2019 and believes CMS should utilize the same tenets from that initiative in attempting to implement these new requirements. While WHA appreciates the goal of including specificity in this new rule, we are concerned that it contains too many unnecessary requirements that will not add to the overall transparency goals but will be burdensome for hospitals to comply with. Put simply, the complexity of this new proposal will require hospitals to spend more time and resources on compliance with little to no benefit for the taxpayers that fund the Medicare program. We urge CMS to minimize unnecessary paperwork and regulatory requirements while providing maximum flexibility for providers that are clearly attempting to make a good-faith effort to comply with the new regulations.

Request for Information on Hospital Price Transparency Data

In Section XXIII, CMS seeks public comment on potential approaches to improve the standardization and comparability of hospital price transparency data, including proposals that could prompt another round of changes to the machine-readable file requirements, as well as modifications to, or the possible elimination of, the current deemed-compliance policy for internet-based price estimator tools.

Since the Hospital Price Transparency Rule took effect in 2021, CMS has made substantive updates to the regulations and related guidance nearly every year, requiring hospitals to devote additional time, staffing, and financial resources to comply with evolving transparency obligations. This burden is compounded when regulatory changes are directed at only one participant in the healthcare transaction rather than being coordinated across all entities subject to federal price transparency requirements. A more aligned and comprehensive approach to healthcare pricing transparency policy would reduce unnecessary administrative costs while improving the consistency, comparability, and usefulness of pricing information for consumers and employers.

Wisconsin hospitals and health systems support and have invested significant time and resources to advance the shared goal of ensuring that patients and employers have access to meaningful, accurate, and actionable health care pricing information. Consistent with that commitment, Wisconsin hospitals have taken their

responsibility to comply with federal Hospital Price Transparency regulations seriously. As of August 14, 2026, CMS had completed 155 hospital price transparency compliance reviews involving 112 Wisconsin hospitals since 2021. In 95% of those reviews (147 of 155), CMS determined that the hospital was in compliance with the requirements or closed the review after compliance was achieved. The remaining eight reviews, all initiated since May 2026, remain under CMS review. The reviews WHA has been made aware of have all been for extremely minor issues with hospitals' files, such as a hospital name change or addresses being in the wrong row or column. Notably, CMS has not imposed a single civil monetary penalty on a Wisconsin hospital for violating Hospital Price Transparency requirements.

CMS also seeks comment on whether hospitals should continue to be deemed compliant with the consumer-friendly display requirements for shoppable services by offering a price estimator tool, as permitted under 45 CFR § 180.60(a)(2). Removing deemed compliance for these tools would be a step backward for patients. WHA strongly urges CMS to retain this option. Hospitals should continue to be permitted to satisfy the consumer-friendly display requirements through an internet-based price estimator tool that is prominently displayed on their websites.

Price estimator tools are more user-friendly than static shoppable services files and provide information patients are seeking, including expected out-of-pocket costs. Additionally, many of these price estimator tools are a component of the hospital or health systems' electronic health record (EHR) systems. If CMS eliminates deemed compliance for price estimator tools, cCMS will be discouraging the most popular tool for patients to use to access cost information for shoppable services. Such a policy would undermine the progress hospitals have made in developing patient-centered transparency tools and divert resources away from solutions that patients and consumers find most useful.

For uninsured individuals and patients who pay cash without using an insurance network, Wisconsin hospitals are already required under the federal No Surprises Act to provide a good faith estimate of expected charges. If the final billed charges exceed the total amount of the good faith estimate by $400 or more, patients may initiate the federal patient-provider dispute resolution process. In addition, hospitals across Wisconsin have invested in price transparency tools that go beyond federal regulatory requirements. As technology and electronic health record integration have advanced, hospitals and health systems have increasingly implemented "push" estimates, which are proactively sent to patients before scheduled services without requiring a patient request.

Hospitals are also deploying price estimation technologies that incorporate patient-specific insurance information to provide more accurate projections of out-of-pocket costs. While health insurers are ultimately responsible for providing benefit and cost-sharing information, hospitals are taking additional steps to help patients better understand their anticipated financial responsibility before receiving care.

Before implementing yet another set of changes to the growing and already complicated hospital price transparency regulations, CMS should undertake a comprehensive review of the broader federal health care price transparency framework. Specifically, WHA joins the American Hospital Association in urging CMS to evaluate how the Hospital Price Transparency requirements, Transparency in Coverage requirements, and the No Surprises Act's Good Faith Estimate and Advanced Explanation of Benefits (AEOB) provisions interact with one another. CMS should identify areas of overlap, inconsistency, and duplication and align these requirements so that each policy serves a distinct purpose without creating unnecessary administrative burden or imposing uneven compliance obligations across the health care system.

OUTPATIENT QUALITY REPORTING PROGRAM

Electronic Clinical Quality Measure (eCQM) Validation

WHA supports CMS's efforts to improve confidence in the accuracy and reliability of electronically reported quality data. We appreciate CMS's proposal to incorporate eCQM validation into the existing Hospital Outpatient Quality Reporting (OQR) Program validation process and agree that accurate quality data are essential to quality improvement initiatives and public reporting.

Given CMS's proposal to require hospitals to achieve a minimum validation score of 75 percent in order to successfully meet validation requirements, it is important that hospitals have meaningful opportunities to review and address identified discrepancies before validation results are finalized. WHA supports CMS's proposal to extend the educational review process to eCQM validation and encourages the agency to provide clear and transparent information regarding how validation discrepancies are evaluated and scored.

WHA also encourages CMS to recognize that eCQM performance and reporting are heavily dependent upon electronic health record configuration, vendor programming, data mapping, and interoperability among health information systems. Accordingly, CMS should ensure that validation findings appropriately distinguish hospital reporting issues from technology-related discrepancies that may be outside a hospital's direct control. As CMS implements this enhanced validation process, continued emphasis on education, transparency, and timely feedback will help ensure the program promotes continuous quality improvement while maintaining fairness for participating hospitals.

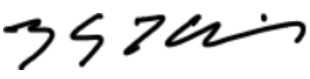
Advance Care Planning eCQM Request for Information

WHA supports the goals of advance care planning and recognizes its importance in promoting patient-centered care, shared decision-making, and alignment of treatment with patient goals and preferences. As CMS notes, an increasing number of services and procedures are shifting from the inpatient setting to hospital outpatient departments, creating new opportunities for clinicians and patients to engage in meaningful advance care planning discussions. However, the outpatient environment differs significantly from the inpatient setting in terms of patient acuity, visit purpose, available time, and established patient-provider relationships.

As CMS considers future quality measurement in this area, WHA encourages the agency to focus on those outpatient encounters and patient populations for whom advance care planning is most clinically relevant and meaningful. A future measure should support genuine conversations that help patients communicate their goals, values, and preferences. CMS should also carefully evaluate documentation expectations and reporting burden to ensure that any future measure can be implemented in a manner that supports patient care and does not inadvertently divert resources from direct patient interaction.

WHA appreciates the opportunity to provide comments on this proposed rule.

Sincerely,



Kyle O'Brien
President & CEO

[i] CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.