NATIONAL HEALTH COUNCIL

September 15, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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 [CMS-1834-P]

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Calendar Year (CY) 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (CMS–1834–P).

Created by and for patient organizations over 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of more than 180 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

General Comments

The NHC evaluates all OPPS/ASC proposals through a set of overarching priorities that reflect our mission to promote increased access to affordable, high-value, comprehensive, and sustainable health care.[1] These priorities guide the comments that follow:

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[1] National Health Council. *NHC Comments on Centers for Medicare & Medicaid Services (CMS) in Response to the Proposed Rule Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies.* September 9, 2024. https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-centers-for-medicare-medicaid-services-cms-in-response-to-the-proposed-rule-medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule-and/.

- **Payment Stability and Predictability:** Abrupt or large negative shifts in reimbursement threaten the viability of hospital outpatient departments, ASCs, and other facilities that serve as essential access points, particularly in rural and other communities with limited provider availability.
- **Access to Care:** Coverage expansions should be paired with practical strategies that ensure beneficiaries can use new services, including infrastructure, technology, and workforce supports that sustain availability across settings.
- **Data-Driven and Transparent Valuation:** Payment methodologies should rely on empirical, auditable, real-world evidence with site-appropriate adjustments, and CMS should employ transparent methods that account for structural differences between hospital outpatient departments, ASCs, and physician offices.
- **Integration of Physical, Behavioral, and Social Care:** Payment reforms should support coordinated, team-based models that reflect the interaction between medical and behavioral health needs and address upstream drivers of health that influence outpatient utilization and outcomes.
- **Support for Safety-Net Providers:** Rural hospitals, cancer centers, Tribal facilities, and other safety-net providers require adequate payment and reduced administrative burden to remain viable and preserve access for Medicare beneficiaries.
- **Meaningful Patient Engagement:** Significant payment and delivery reforms should incorporate structured input from patients and caregivers, with CMS reporting how this feedback informs final policies and implementation.

The CY 2026 OPPS/ASC proposed rule makes progress in several areas—such as continuation of site-of-service protections for radiation therapy, expansion of non-opioid pain management policies, and refinements to behavioral health and preventive service coverage—while also raising concerns about the cumulative effects of layered payment changes, including Ambulatory Payment Classification (APC) recalibrations, conversion factor updates, and wage index adjustments. In addition, proposals affecting transparency, quality reporting, and acquisition cost surveys may increase administrative demands without clear assurances that patients will benefit from improved affordability or access. The NHC encourages CMS to pair technical updates with strong transparency and monitoring. Specifically, CMS should phase in material negative impacts to avoid abrupt disruptions in care; publish disaggregated facility- and service-level impact analyses; retain and strengthen documentation of upstream drivers of health so they are appropriately recognized and resourced; and expand post-implementation monitoring of access, quality, and patient experience, with mechanisms for mid-course correction where reforms fail to support patient-centered outcomes and sustainable care delivery.

Payment Stability and Predictability

Ensuring that OPPS policies provide stable and predictable reimbursement is essential to sustaining access to outpatient services for Medicare beneficiaries, as abrupt or poorly calibrated changes in payment policy can undermine service lines, accelerate consolidation, and limit the availability of care in rural and safety-net settings. The CY 2026 proposals on APC recalibration, conversion factor updates, wage index

refinements, cost-to-charge (CCR) ratios, supplemental payments for rural and cancer hospitals, and outlier protections all illustrate how what appear to be technical adjustments can produce significant real-world consequences for patients.

The recalibration of APC relative payment weights can result in sharp redistributive impacts.[2] Without adequate transitional buffers, these shifts may prompt hospitals to reduce or even discontinue essential services, with patients experiencing the effect as a reduction in local options for diagnostic, interventional, or infusion care. The NHC therefore recommends that CMS adopt transitional protections when recalibrations reduce payment for essential services by more than a modest threshold. Furthermore, the agency should publish service-specific impact tables so that all stakeholders can anticipate and mitigate any potential disruptions to access. In addition, we emphasize that OPPS data, while appropriate for calibrating hospital outpatient services, must not be applied unadjusted to physician office settings, as the structural and scale differences between hospitals and offices make such cross-setting comparisons inappropriate without site-specific adjustments grounded in auditable data.

The proposed 2.8 percent OPPS conversion factor update is nominally positive yet remains below measured hospital input cost growth.[3] The persistent misalignment between conversion factors and empirical indices erodes the real value of payments over time, which threatens the sustainability of services and ultimately affects whether patients can obtain timely, affordable care. We urge CMS to explicitly compare OPPS updates against the hospital market basket and provide clear justification for any departures from those measures, just as we recommended in the Physician Fee Schedule (PFS) context with the Medicare Economic Index.

Wage index refinements, while intended to improve accuracy, have the potential to destabilize facilities in low-wage or rural areas if implemented abruptly.[4] Reductions driven by index shifts may cause outpatient service closures, which in turn would force patients to travel farther or delay their care. CMS should therefore phase in any significant changes and monitor their effects on travel times and service availability to ensure that methodological corrections do not inadvertently harm patient access. Similar concerns are raised by updates to statewide default CCRs, as inaccurate defaults may distort reimbursement and destabilize hospitals that treat high-cost populations.[5] The NHC recommends that CMS ensure transparency in its methodology

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[2] Jeffrey Clemens and Joshua Gottlieb, “In the Shadow of a Giant: Medicare’s Influence on Private Physician Payments.” *Journal of Political Economy* 125, no. 1 (February 2017): 1–39. https://doi.org/10.1086/689772.

[3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC, June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[4] Ge Bai et al., “Varying Trends in the Financial Viability of US Rural Hospitals, 2011–17.” *Health Affairs* 39, no. 6 (2020): 942–48. https://doi.org/10.1377/hlthaff.2019.01545.

and provide opportunities for stakeholder review, particularly in states with wide variability across hospitals.

The continuation of supplemental adjustments for rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) remains essential for sustaining access in fragile markets.[6,7] However, these supports must be linked with accountability measures to demonstrate that financial protections are actually preserving access. CMS should publish annual data on outpatient service availability, including any closures or reductions of service lines in rural areas, to ensure that these supplemental payments are tied to tangible results for patients. Similarly, cancer hospitals play a vital role in offering high-complexity therapies such as infusions and radiation treatments; CMS proposes to continue their payment adjustments, and we refer to our detailed comments in the "Rural Hospital and Safety-Net Provider Protections" section for further recommendations on the adequacy and accountability of these payments.

Outlier protections are critical for patients with rare or medically complex conditions who require high-cost interventions.[8] CMS should maintain robust thresholds and publish patient-level simulations to demonstrate that facilities remain willing to treat these populations. Although technical refinements to the adjusted payment methodology and beneficiary copayments may seem modest in appearance, they can still significantly affect affordability and provider willingness to deliver care. CMS should therefore provide clear, illustrative examples of how these adjustments alter out-of-pocket costs for beneficiaries so that patients and advocates can anticipate their real-world impacts.

Finally, while MedPAC recommendations, the Medicare Safety Net Index, and analyses related to market-based Medicare Severity-Diagnosis Related Group weights and economic modeling may provide useful context for evaluating OPPS adequacy, reliance on aggregate measures should not be a substitute for patient-centered evaluation. CMS must ensure that efficiency considerations do not overshadow the primary goal of preserving access, particularly for beneficiaries who rely on rural hospitals, cancer centers, and other safety-net facilities.

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[5] RAND Corporation, *Practice Expense Methodology and Data Collection Research and Analysis.* RR-2166-CMS. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research_reports/RR2166.html.

[6] Ge Bai et al., “Varying Trends in the Financial Viability of US Rural Hospitals, 2011–17.” *Health Affairs* 39, no. 6 (2020): 942–48. https://doi.org/10.1377/hlthaff.2019.01545.

[7] Gopal Singh and Mohammad Siapush, “Widening Rural-Urban Disparities in All-Cause Mortality and Mortality from Major Causes of Death in the USA, 1969–2009.” *Journal of Urban Health* 91, no. 2 (2014): 272–292. https://doi.org/10.1007/s11524-013-9847-2.

[8] American Hospital Association, "Medicare's LTCH Outlier Policy Needs Reforms to Protect Extremely Ill Beneficiaries," white paper, February 2024, https://www.aha.org/system/files/media/file/2023/12/white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries.pdf.

Access to Care and Patient-Centered Safeguards

Timely, affordable, and appropriate access to outpatient services is a critical concern for all Medicare beneficiaries and a central criterion by which the NHC evaluates all OPPS reforms. The CY 2026 proposals include updates to APC groupings, site-of-service determinations, supervision policies, coverage of new technologies, and ASC payment. While many of these appear technical, their cumulative effect can reshape whether and how beneficiaries receive care across hospital outpatient departments, freestanding ASCs, and community settings. An example of this is how initial APC assignments for new and revised Healthcare Common Procedure Coding System codes can impact access. If reimbursement is set too low, hospitals may delay adoption, limiting access to new therapies at the time of market entry. The NHC recommends that CMS ground these determinations in empirical evidence of real-world resource use and solicit structured patient and caregiver input where codes address unmet needs such as rare diseases or high-burden chronic conditions. Likewise, wide variation within APCs creates unpredictability that can disincentivize hospitals from furnishing complex imaging, interventional, or novel therapies.[9] CMS should publish variance data by APC and explicitly evaluate how such variation affects patient access to high-value services.

The new technology APC pathway remains vital for bringing innovative services to patients before sufficient evidence exists for permanent APC assignment.[10] CMS' proposed refinements are appropriate, but adoption decisions will only be reliable if patients and caregivers are formally engaged in reviewing applications. Incorporating their perspectives can ensure that payment decisions reflect unmet needs and treatment burdens. CMS' policy for universal low-volume APCs should also be monitored closely; while intended to improve accuracy, broad groupings may inadvertently reduce incentives to maintain access to rare but clinically essential services, such as complex brachytherapy regimens.

Other proposals touch directly on site-of-service policy and supervision. Continued protections for radiation therapy services at nonexcepted off-campus provider-based departments (PBDs) are essential to preserve access for patients with cancer who might otherwise face long travel burdens.[11] While largely administrative, technical refinements to outpatient visits and critical care coding can still affect provider

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[9] Brady Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," *Health Services Research* 56, no. 1 (January 2021): 7–15, https://doi.org/10.1111/1475-6773.13613.

[10] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[11] Sifan Grace Lu, Kunal Sindhu, and Jared Rowley, "Changes in Employment and Practice Locations Among Radiation Oncologists: 2015–2023," *International Journal of Radiation Oncology, Biology, Physics* 122, no. 5 (August 1, 2025): 1095–1101, https://doi.org/10.1016/j.ijrobp.2025.02.036.

willingness to furnish these services.[12] The NHC recommends that CMS monitor visit utilization rates after implementation to ensure that beneficiaries with multiple chronic conditions do not lose timely access to complex management in outpatient settings. Methodology changes to the inpatient-only list must also be applied with transparent, patient-centered criteria and evaluated through real-world outcomes such as complication rates, readmissions, and patient- and caregiver-reported barriers.

The NHC also appreciates CMS' request for information (RFI) on whether and how OPPS payment should be adjusted for services predominately performed in ASC or physician office settings. Any cross-setting relativity changes should rely on empirical, auditable data; incorporate site-appropriate cost structures and quality/safety considerations; and be phased in with guardrails that prevent abrupt negative impacts on access, particularly in rural and safety-net markets. We also recommend publishing service-level impact analyses and monitoring for site-of-care shifts, wait times, and beneficiary travel burdens before expanding any such adjustments.

Several nonrecurring proposals in the rule further affect patient access, such as the policies CMS proposes to control growth in outpatient services at excepted off-campus PBDs. Policies aimed at controlling unnecessary volume could reduce access to services in community-based settings if not implemented with safeguards.[13] The NHC recommends that CMS pair any such controls with monitoring of wait times and travel distances. CMS also proposes to continue medical review of certain inpatient admissions under Medicare Part A. Although essential for program integrity, medical reviews must not create delays in patient discharge or post-acute transitions.[14] Finally, CMS proposes refinements to coverage of Category B Investigational Device Exemption devices and studies. The NHC supports expanded access to clinical trials but stresses the importance of clear, standardized communication to patients and caregivers regarding coverage rules and out-of-pocket obligations to ensure that financial uncertainty does not deter participation.[15]

Other proposals in the rule, such as payment status indicators, while technical in nature, also have an impact on patient access as they dictate how services are categorized and reimbursed. CMS should provide plain-language explanations of these designations so patients and advocates understand what is covered and why. Similarly, ASC payment updates have direct access implications. Expanding the ASC covered procedures list

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[12] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*.

[13] Bipartisan Policy Center, "Paying the 2025 Tax Bill: Site Neutrality in Medicare Payment," April 11, 2025, https://bipartisanpolicy.org/explainer/paying-the-2025-tax-bill-site-neutrality-in-medicare-payment/.

[14] US Department of Health and Human Services, Office of Inspector General, "Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided" (report A-05-12-00053, May 1, 2012).

[15] Sharon Phares et al., "Managing the Challenges of Paying for Gene Therapy: Strategies for Market Action and Policy Reform in the United States," *Journal of Comparative Effectiveness Research* 13, no. 12 (November 14, 2024): e240118, https://doi.org/10.57264/cer-2024-0118.

can increase beneficiary choice, but CMS must ensure that outcomes in ASCs are equivalent to hospital outpatient departments. Continuation of the non-opioid pain management policy is especially important as part of national efforts to reduce opioid dependence. For New Technology Intraocular Lens designations, CMS should ensure that patient perspectives are explicitly incorporated into evaluations of whether technologies improve functional outcomes and quality of life.

These proposals illustrate how technical adjustments in OPPS and ASC payment can significantly affect patient access. The NHC urges CMS to evaluate each change not only for budget neutrality and administrative feasibility, but also for whether it advances timely, affordable, and appropriate access to outpatient services across all sites of care.

Transparency, Quality Reporting, Star Ratings, and Price Disclosure

Transparency in hospital outpatient payment and reporting is fundamental to patient empowerment, as beneficiaries require clear, actionable information to make informed decisions about where to seek care, anticipate their costs, and evaluate the quality of services.[16] The collective effect of the CY 2026 OPPS proposals on quality reporting, star ratings, hospital price transparency, and information collection requirements is to shape whether Medicare beneficiaries can meaningfully engage in their care; while these initiatives have the potential to improve patient decision-making, they must be designed to ensure accuracy, interpretability, and usability while minimizing any unnecessary burden on stakeholders.

CMS' proposed updates to the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) programs represent a constructive step towards aligning performance measurement across sites of service.[17] However, the addition of new measures, particularly those addressing whole-person care such as nutrition, caregiver well-being, and functional status, must be carefully grounded in structured patient engagement. For example, a nutrition-related measure should not only assess whether dietary counseling is offered but also whether patients can reliably access affordable, healthy food, and data collection and reporting must be managed in a way that preserves accuracy and timeliness while avoiding excessive administrative burden. Usability testing with patients and caregivers is critical to ensuring these measures are both understandable and actionable.

Furthermore, updates to the OQR program, including revisions to the measure set, submission processes, and data timeliness, should be implemented to strengthen reporting without undermining its value to patients. The NHC recommends that CMS apply payment reductions consistently when hospitals fail to meet reporting requirements, thereby preserving accountability and comparability across facilities. In the REHQR program, while alignment with OQR and ASCQR measures can streamline

[16] Danielle Lavallee et al., "Incorporating Patient-Reported Outcomes into Health Care to Engage Patients and Enhance Care," *Health Affairs* 35, no. 4 (April 2016): 575–582, https://doi.org/10.1377/hlthaff.2015.1362.

[17] Lavallee et al., "Incorporating Patient-Reported Outcomes."

reporting, the measures themselves must be tailored to the unique realities of rural settings, capturing barriers such as travel distances, specialty shortages, and extended wait times.[18] For the ASCQR program, patient-centered measures are important, but CMS must avoid overwhelming smaller facilities with requirements that could jeopardize their sustainability, making technical assistance and streamlined reporting pathways essential.

The Overall Hospital Quality Star Rating remains one of the most visible public reporting tools for patients, and any methodological changes that affect ratings without reflecting real performance shifts can compromise confidence in the system. Therefore, CMS should pair all methodological updates with clear, plain-language communication to patients, caregivers, and advocates about how the ratings are calculated and what they truly represent.

The NHC supports CMS' proposals to strengthen hospital price transparency through improved disclosure and enforcement, although we believe compliance alone is insufficient.[19] Patients require information about their out-of-pocket costs in standardized, machine-readable formats with plain-language descriptors that are linked where possible to quality metrics; this ensures that price transparency enhances, rather than confuses, patient decision-making.[20] Enforcement should be timely, consistent, and proportionate, with penalties that are sufficient to deter noncompliance.

Finally, while oversight is important for the multiple information collection requirements that CMS proposes—including those related to quality reporting programs, payer-specific negotiated charges, drug acquisition cost surveys, and hospital price transparency—duplicative or poorly aligned requirements may divert resources from patient care. The NHC supports streamlined, interoperable systems that reduce redundancy and maximize value. It is critical for CMS to ensure all collected data yields actionable insights for patients and caregivers, rather than serving solely as a compliance exercise. These transparency and reporting policies have the potential to improve patient choice and accountability across both OPPS and ASC settings. To realize this potential, CMS must embed structured patient engagement in the development of measures, prioritize the usability and interpretability of all reported data, and ultimately ensure that transparency translates into real-world value for beneficiaries.

Behavioral Health and Preventive Services

Behavioral health and preventive services are essential pillars of outpatient care, as behavioral health interventions often determine whether people with chronic conditions,

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[18] National Rural Health Association, "National Rural Health Association Policy Brief," accessed August 29, 2025, https://www.ruralhealth.us/nationalruralhealth/media/documents/nrha-impact-of-telehealth-policy-on-rural-health-access-2024.pdf.

[19] Lavallee et al., "Incorporating Patient-Reported Outcomes."

[20] Joseph Firth et al., "The Lancet Psychiatry Commission: A Blueprint for Protecting Physical Health in People with Mental Illness." *The Lancet Psychiatry* 6, no. 8 (2019): 675–712. https://doi.org/10.1016/S2215-0366(19)30132-4.

disabilities, or complex needs can follow their treatment regimens, avoid unnecessary hospitalizations, and preserve their quality of life.[21] Preventive services such as cancer screenings are equally vital, offering critical opportunities to detect disease early and reduce the need for higher-cost interventions later on. Therefore, the CY 2026 OPPS proposals in these areas must be evaluated through the comprehensive lens of patient access, affordability, and long-term health outcomes.

CMS proposes refinements to payment for partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs); these services provide structured, multidisciplinary care for patients in crisis, but their availability is often constrained by underfunding and workforce shortages.[22] The NHC recommends that CMS align payment rates with the actual costs of delivering multidisciplinary care, including psychiatry, counseling, nursing, and peer supports. Without such alignment, PHPs and IOPs risk contraction in the very areas where they are most needed, particularly in rural and other communities with limited provider availability.[23] To ensure that reforms translate into improved access for all beneficiaries, CMS should also monitor utilization and outcomes stratified by geography and population characteristics such as age, disability status, and language proficiency. In addition, the evaluation of PHP and IOP policies should incorporate structured patient and caregiver engagement to ensure that coverage decisions reflect the real-world experiences of navigating care, continuity, and recovery supports.

The proposed rule also includes refinements to preventive service coverage under OPPS, with a particular focus on colorectal cancer screening, and the NHC supports the continued expansion of preventive services with no patient cost-sharing. However, coverage alone is insufficient if patients face barriers such as transportation, language access, or digital literacy, and we recommend that CMS establish a structured process for incorporating patient and caregiver feedback into evaluations of preventive coverage to ensure that these services are not only covered but are also realistically accessible. Looking forward, we believe that OPPS should remain a vehicle for incorporating new, evidence-based preventive interventions—including those targeting cardiovascular disease, diabetes, and infectious diseases—so that beneficiaries can benefit quickly from advances in scientific knowledge.

Several of CMS' proposed updates to quality reporting programs, including the RFI on Nutrition and Well-Being, intersect directly with preventive health. While measures addressing social and nutritional determinants of health have the potential to capture the upstream drivers of patient outcomes, they must be designed carefully to ensure they reflect patient priorities rather than simply process metrics.[24] For example, a

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[21] Singh et al., "Widening Rural-Urban Disparities."

[22] NRHA, "National Rural Health Association Policy Brief."

[23] Ge Bai et al., "Varying Trends in the Financial Viability of US Rural Hospitals."

[24] Jonathan Jaffery and Dana Gelb Safran, "Addressing Social Risk Factors in Value-Based Payment: Adjusting Payment Not Performance to Optimize Outcomes and Fairness," *Health Affairs Forefront*, April 19, 2021, https://doi.org/10.1377/forefront.20210414.379479.

nutrition-related measure should assess whether dietary counseling is offered as well as whether patients have reliable access to affordable, healthy food. Similarly, measures of well-being should also consider caregiver burden and functional ability, as these factors directly influence a patient's ability to adhere to preventive care. By embedding preventive health and behavioral health within both payment policy and quality reporting, CMS has an opportunity to better integrate a whole-person approach to care. The NHC therefore urges CMS to ensure that these services are reimbursed at levels that reflect their true costs, are accessible to all beneficiaries without financial or logistical barriers, and are consistently monitored for real-world effectiveness using patient-centered outcomes.

Rural Hospital and Safety-Net Provider Protections

Rural hospitals, Tribal facilities, cancer centers, and other safety-net providers are critical to the Medicare program. They predominantly serve patients with complex medical needs, low incomes, or limited alternatives for care, yet they often operate on thin margins and remain highly sensitive to reimbursement changes.[25] Decades of research demonstrate that rural hospitals face heightened financial risk compared with urban counterparts, with closure rates increasing in recent years and widening disparities in mortality outcomes for patients living in rural communities.[26] Safety-net providers also face distinct challenges as they care for populations with higher rates of disability, chronic illness, and socioeconomic disadvantage.[27] The proposals on rural and cancer hospital adjustments, Rural Emergency Hospital (REH) quality reporting, and graduate medical education (GME) accreditation therefore carry significant implications for whether vulnerable patients can continue to rely on these facilities as lifelines for outpatient care.

Continuation of payment adjustments for Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) is vital to sustaining access in communities where a single hospital may be the only provider of outpatient services.[28] Without these protections, facilities that serve as the sole access point for entire regions may be forced to scale back or close service lines, resulting in longer travel times, delayed care, or loss of access altogether.[29] The NHC supports continuation of these adjustments but recommends pairing them with accountability mechanisms to ensure that financial supports translate into preserved access. For example, CMS should

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[25] Ge Bai et al., "Varying Trends in the Financial Viability of US Rural Hospitals."

[26] Singh et al., "Widening Rural-Urban Disparities."

[27] Nazleen Bharmal et al., *Understanding the Upstream Social Determinants of Health,* RAND Health Working Paper WR-1096-RC (Santa Monica, CA: Rand Corporation, 2015), https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1096/RAND_WR1096.pdf.

[28] NRHA, "National Rural Health Association Policy Brief."

[29] Sterling Ransone Jr., "How Medicare's broken pay system harms rural patients, physicians," *AMA News Wire*, January 27, 2025.

publish annual data on the availability of key outpatient services in rural areas, using existing datasets where possible, and convene structured stakeholder input sessions to gather perspectives from patients, caregivers, and providers. Embedding accountability will demonstrate that supplemental payments yield measurable improvements in access rather than simply stabilizing finances.

Similarly, Rural Emergency Hospitals (REHs) require specific policy support. Their quality reporting requirements must reflect the unique challenges of geographically isolated care. While alignment with other reporting programs can reduce administrative burden, measures must capture access outcomes that are meaningful in rural contexts, such as travel distance, availability of specialty services, and wait times for urgent outpatient care.[30] Patient voices from rural and Tribal communities should inform both the design and refinement of REH quality measures, ensuring that policies reflect lived experiences rather than abstract performance metrics. Tailoring measures to rural realities will help avoid unintended consequences where uniform requirements could impose high burden without capturing meaningful differences in access.

Payment adjustments are also crucial for cancer hospitals, which often adopt cutting-edge therapies such as high-cost infusions and advanced radiation treatments. Without appropriate adjustments, these institutions risk curtailing access for Medicare beneficiaries.[31] Cancer centers not only deliver highly specialized care but also serve as hubs for clinical trials and novel therapies, particularly in oncology and immunology.[32] The NHC supports continuation of cancer hospital adjustments and recommends that CMS assess adequacy in terms of patient-centered outcomes such as treatment completion rates, timeliness of therapy initiation, and quality-of-life measures reported directly by patients and caregivers. Transparent reporting on how cancer hospital adjustments translate into preserved or expanded access to innovative therapies would strengthen accountability while ensuring that patients with life-threatening conditions are not left behind.

Finally, expanding and sustaining GME opportunities in outpatient and safety-net settings is essential to addressing persistent workforce shortages. Shortages of physicians, behavioral health providers, and allied health professionals are especially acute in rural areas, where provider recruitment and retention remain ongoing challenges.[33] Incentivizing medical training in rural and safety-net facilities can help build a pipeline of clinicians prepared to practice in rural and other communities with limited access to care, directly benefiting patients by preserving access to outpatient services. The NHC therefore supports CMS' efforts to sustain and expand GME

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[30] NRHA, "National Rural Health Association Policy Brief."

[31] Phares et al., "Managing the Challenges of Paying for Gene Therapy."

[32] Phares et al., "Managing the Challenges of Paying for Gene Therapy."

[33] Committee on Improving Primary Care Valuation Decisions for the Physician Fee Schedule, National Academies of Sciences, Engineering, and Medicine, *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule* (Washington, DC: National Academies Press, 2024).

accreditation pathways that encourage residency and fellowship training in these contexts.

Taken together, these policies highlight the importance of not only maintaining but strengthening protections for rural and safety-net providers. By linking supplemental payments to accountability for patient access, embedding structured feedback from affected communities, and aligning training investments with areas of greatest need, CMS can ensure that these institutions remain reliable sources of outpatient care for Medicare beneficiaries. Sustaining these providers is not only essential to ensure patient access but also for the long-term sustainability of the Medicare program as it adapts to patients' evolving clinical needs.

Pass-Through and OPPS Drug/Device Policies

Ensuring timely access to innovative drugs, biologics, radiopharmaceuticals, and devices is central to the OPPS pass-through payment policy, as these can mean the difference between cutting-edge therapies and care delays for patients with chronic, complex, or rare conditions.[34] he CY 2026 proposals—spanning pass-through devices and procedures, drugs and biologics, packaging and acquisition policies, aggregate spending limits, non-opioid pain management, and drug acquisition cost surveys—each carry direct implications for whether Medicare beneficiaries can obtain lifesaving therapies without undue financial or logistical barriers.

Continuation of pass-through status for devices and updates to the list of device-intensive procedures are important tools for reducing barriers to the adoption of new technologies in outpatient settings. However, when pass-through status abruptly expires, it can suddenly shift costs and create affordability challenges for patients when devices are bundled into APCs.[35] The NHC recommends that CMS evaluate transition strategies that balance fiscal oversight with continuity of patient access, particularly for high-need therapies with limited alternatives. CMS should also clearly communicate the timing and criteria for these policies so hospitals can plan for technology adoption without disrupting patient treatment pathways.

For drugs, biologicals, and radiopharmaceuticals, the transitional pass-through payment pathway remains critical for accelerating access to breakthrough therapies in oncology, neurology, and rare disease treatment.[36] The NHC supports the continuation of these policies and encourages CMS to strengthen predictability by clarifying evaluation criteria for pass-through applications and timelines, allowing applicants, providers, and patients to anticipate coverage and payment with fewer mid-course adjustments. At the same time, reimbursement for products without pass-through status—whether based on ASP+6 percent or through packaging into APCs—must be monitored closely for impacts on patient affordability and provider willingness to furnish therapies. Bundling policies can make treatments inaccessible for patients with rare or high-cost conditions, and

[34] Phares et al., "Managing the Challenges of Paying for Gene Therapy."

[35] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*.

[36] Phares et al., "Managing the Challenges of Paying for Gene Therapy."

carve-outs may be warranted in those cases.[37] Transparency in how these packaging determinations are made and how they ultimately affect coinsurance at the service level will be essential to maintaining the trust of both patients and providers.

CMS' estimate of aggregate pass-through spending and application of statutory limits should not be allowed to restrict patient access to high-value therapies. To ensure safeguards are appropriately calibrated, CMS should publish analyses showing how spending caps affect specific categories such as oncology, rare diseases, and advanced diagnostics. This would help stakeholders assess whether limits create unintended barriers and inform any mid-course corrections that might be needed.

Beyond pass-through policies, broader policy changes that alter the ASP—such as incorporation of Maximum Fair Prices from the Inflation Reduction Act or any reintroduction of Most Favored Nation-style reference pricing—would have downstream effects on hospital outpatient payments. Depressed ASP values could significantly reduce OPPS add-on payments and destabilize reimbursement for infusion and injection services, particularly in oncology and immunology.[38] These effects may accelerate consolidation and diminish access to community-based infusion care, leaving patients with fewer local options and greater reliance on hospital outpatient departments.[39] To protect patients, the NHC urges CMS to clarify that MFPs are not intended to function as default reimbursement limits under OPPS and to continue publishing ASP values exclusive of MFP-discounted units so that multi-payer contracts and OPPS rates remain stable. The ongoing drug acquisition cost survey, while valuable for ensuring empirically grounded reimbursement, also imposes administrative demands on hospitals and suppliers. The NHC recommends that CMS explore ways to streamline survey processes, minimize burden, and provide transparency about how results are used to stabilize access and affordability.

Finally, the continuation of non-opioid pain management policies under both OPPS and ASC payment systems is another important aspect of access. Expanding coverage of non-opioid alternatives is essential to addressing the opioid crisis while maintaining effective pain management.[40] The NHC recommends that CMS monitor utilization across patient groups to confirm consistent access, evaluate whether uptake reflects clinical need, and consider refinements that encourage safe and effective adoption of innovative alternatives.

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[37] Milena Sullivan et al., "Estimating the Spillover Impact of IRA Part B Negotiation," *Avalere Health,* January 27, 2025, https://advisory.avalerehealth.com/insights/estimating-the-spillover-impact-of-ira-part-b-negotiation.

[38] Michelle Robb, Katherine Holcomb, and Ivanna Ulin, *Impact of Inflation Reduction Act on Part B Provider Payment and Patient Access to Care* (Milliman, May 2025), https://www.milliman.com/en/insight/ira-impact-on-part-b-provider-payments.

[39] Post et al., "Hospital-Physician Integration."

[40] Firth et al., "The Lancet Psychiatry Commission."

Overall, these proposals demonstrate the importance of designing pass-through, packaging, and acquisition policies that safeguard timely and affordable access to innovation. The NHC urges CMS to ensure that fiscal oversight does not overshadow patient-centered goals and that payment pathways for emerging therapies remain transparent, predictable, and aligned with the real-world needs of Medicare beneficiaries.

Prior Authorization and Utilization Management

The NHC recognizes that prior authorization and related utilization management tools can serve an important role in promoting program integrity and supporting appropriate utilization of outpatient services. These policies can help ensure that care is evidence-based and resources are used effectively. However, if applied too broadly or without a clear empirical foundation, prior authorization can unintentionally delay care, increase administrative burden, and undermine patient–provider trust. For individuals with chronic or complex conditions, even short delays in outpatient services can lead to serious clinical consequences such as disease progression, avoidable hospitalizations, and reduced quality of life.[41] The CY 2026 OPPS proposals in this area—including expansion of prior authorization requirements, continuation of virtual supervision flexibilities, medical review of inpatient admissions, and updates to investigational device coverage—must therefore be evaluated with balance, ensuring that program integrity is maintained while timely patient access is preserved. The NHC urges CMS to ensure that any expansion is empirically justified, narrowly targeted to address documented patterns of inappropriate utilization, and supported by auditable utilization and outcomes data. Where feasible, less burdensome alternatives should be prioritized, and thresholds should be transparent to providers and patients alike. Prior authorization should remain a precision tool rather than a blunt instrument, ensuring that cost containment and integrity objectives do not overshadow clinical appropriateness or timely access to care.

In contrast, CMS' proposal to extend virtual direct supervision for cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation, and certain diagnostic services, illustrates how regulatory flexibility can improve access. Allowing providers to supervise these services virtually has the potential to expand availability for patients in rural and other communities with limited provider availability, provided that appropriate safeguards are in place.[42] The NHC supports continuation of this flexibility and recommends that CMS monitor outcomes such as patient satisfaction, program completion rates, and safety indicators to ensure quality is maintained. Clear guidance on quality guardrails will be critical for ensuring consistent implementation. These recommendations align with our comments on the Physician Fee Schedule proposed

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[41] American Medical Association, "AMA Prior Authorization and Patient Harm Survey," June 18, 2024, https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-indicates-prior-authorization-wreaks-havoc-patient-care.

[42] Lisa Koonin et al., "Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020," *MMWR. Morbidity and Mortality Weekly Report* 69, no. 43 (2020): 1595–99, https://doi.org/10.15585/mmwr.mm6943a3.

rule, where we similarly supported durable supervision flexibilities when paired with patient protections.[43]

The continuation of medical review for specific inpatient admissions under Medicare Part A also warrants careful attention. While oversight is appropriate to ensure admissions are clinically justified, review processes can introduce uncertainty and delays in transitions of care.[44] The NHC recommends that CMS streamline these processes to minimize disruption and implement safeguards to prevent delays in discharge or post-acute transitions that could negatively affect patients and caregivers.

Finally, the proposed updates to coding and payment for Category B investigational device exemption (IDE) studies are critical to patients who often rely on clinical trials for access to novel therapies.[45] The NHC supports continued coverage of IDE devices but emphasizes the importance of clear, plain-language communication to patients and caregivers regarding eligibility, cost-sharing responsibilities, and participation rights. Payment policies should also be structured to minimize financial barriers that could discourage trial participation, particularly for patients in rural and resource-limited areas where opportunities for research involvement may already be limited.

Taken together, these policies illustrate the dual role of utilization management: when designed and targeted effectively, it can support program sustainability and expand access to appropriate care; when poorly structured, it risks creating barriers that harm patients. The NHC urges CMS to ensure that all utilization management policies are transparent, data-driven, patient-centered, and implemented with safeguards that preserve timely and reliable access.

Social Risk and Upstream Drivers of Health Documentation

Improving health outcomes and reducing long-term costs in Medicare depends not only on clinical services but also on addressing upstream drivers of health such as housing stability, food access, transportation, caregiver support, and social connection.[46] For patients with chronic or complex conditions, these nonmedical factors often determine whether treatment plans are followed, preventive care is obtained, and acute episodes are avoided.[47] The CY 2026 OPPS proposed rule presents both opportunities and risks in this area, and alignment with the CY 2026 PFS proposals will be essential to ensure that documentation of upstream drivers is preserved and consistently recognized across

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[43] National Health Council, "NHC Submits Comments on CY 2026 Physician Fee Schedule Proposed Rule," September 12, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-submits-comments-on-cy-2026-physician-fee-schedule-proposed-rule/.

[44] HHS OIG, "CMS Should Improve."

[45] Phares et al., "Managing the Challenges of Paying for Gene Therapy."

[46] Bharmal et al., *Understanding the Upstream Social Determinants of Health*.

[47] Jaffery and Safran, “Addressing Social Risk Factors.”

care settings, particularly for non–Evaluation and Management (E/M) billing professionals who play a central role in connecting patients with needed resources.[48]

CMS' RFI on new measure concepts in nutrition, food insecurity, and patient well-being illustrates the potential of integrating upstream drivers into quality reporting.[49] If designed thoughtfully, such measures can highlight barriers that directly influence patients' ability to maintain preventive and chronic care. However, if designed narrowly, they risk capturing only process metrics that do little to improve outcomes.[50] For example, a nutrition measure should assess not only whether dietary counseling was offered but also whether patients can reliably access affordable, healthy food.[51] Measures of well-being should similarly consider caregiver burden, functional ability, and mental health, which directly shape patients' ability to adhere to treatment regimens.[52] To ensure meaningful design, CMS should engage patients and caregivers directly in developing these measures so they reflect real-world needs rather than compliance exercises.

At the same time, CMS has indicated that it may narrow or eliminate codes supporting social risk assessments in outpatient settings, which could diminish incentives for providers to identify and address upstream needs.[53] The NHC recommends retaining these codes under a clearer and less stigmatizing framework such as "Upstream Drivers of Health (UDH) Assessment and Navigation."[54] CMS should also align the codes with existing reporting requirements to minimize duplicative burden and extend billing eligibility to non-E/M professionals with parity across OPPS and PFS, ensuring that the professionals most engaged in this work are appropriately recognized.[55]

Consistency and interoperability must also be strengthened if documentation of social risk is to achieve its intended impact. Aligning OPPS policies with standardized Z-codes, investing in uniform definitions and provider training, and reinforcing privacy protections are critical steps to ensure patients understand how their information will be used and can trust that disclosures will improve their care rather than create new risks.

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[48] NHC, "NHC Submits Comments on CY 2026 Physician Fee Schedule Proposed Rule."

[49] Jaffery and Safran, "Addressing Social Risk Factors."

[50] Lavallee et al., "Incorporating Patient-Reported Outcomes."

[51] Jaffery and Safran, "Addressing Social Risk Factors."

[52] Lavallee et al., "Incorporating Patient-Reported Outcomes."

[53] Jaffery and Safran, "Addressing Social Risk Factors."

[54] National Health Council, "NHC Comments on Centers for Medicare & Medicaid Services (CMS) in Response to the CY 2025 OPPS Proposed Rule," October 10, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-centers-for-medicare-medicaid-services-cms-in-response-to-the-cy-2025-opps-proposed-rule/.

[55] NHC, "NHC Submits Comments on CY 2026 Physician Fee Schedule Proposed Rule."

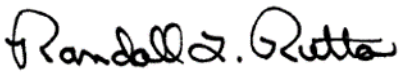
Finally, patient and caregiver engagement must be embedded in the design and oversight of social risk documentation frameworks. Structured listening sessions with populations most affected by upstream barriers would ensure that policies reflect lived experience, while feedback mechanisms for patients and caregivers would provide ongoing accountability for whether coding and reporting frameworks capture the realities of navigating care. Without such safeguards, documentation risks devolving into a bureaucratic exercise rather than a tool for improving outcomes.

By retaining and strengthening social risk assessment codes, aligning policies with standardized documentation practices, and institutionalizing patient and caregiver engagement, CMS can ensure that OPPS reforms advance a whole-person approach to care, one that recognizes and addresses the upstream drivers most critical to Medicare beneficiaries.

Conclusion

Thank you for the opportunity to provide feedback on the CY 2026 OPPS proposed rule. The NHC stands ready to collaborate with CMS to ensure these policies advance payment stability, patient access, and improved outcomes for people living with chronic diseases and disabilities. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org, or Shion Chang, Senior Director, Policy & Regulatory Affairs, at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



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