NATIONAL HEALTH COUNCIL

August 31, 2026

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

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 Data; Prior Authorization; Accrediting Organization Deeming for Emergency Medical Treatment and Labor Act; and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots [CMS-1850-P]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Calendar Year (CY) 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule. The proposed rule includes a wide range of payment, site-of-service, utilization management, quality reporting, transparency, and program-integrity policies that, although often technical in construction, will determine whether Medicare beneficiaries can obtain needed outpatient care in a timely manner, whether the setting in which that care is delivered reflects clinical need rather than payment incentives, and whether the information available to patients is useful for real-world decisions about treatment and affordability.

The NHC unites nearly 200 national organizations—including leading patient groups, research institutions, providers, caregivers, and businesses across the health care sector—to drive patient-centered health policy. Representing 200+ million Americans with chronic diseases and disabilities, the NHC strengthens its members' collective influence to expand access to quality, affordable, and equitable health care. The NHC fosters collaboration to shape policies that reflect the needs of patients.

Across its prior comments on OPPS and ASC rulemaking, the NHC has consistently emphasized payment stability and predictability; empirical, transparent, and appropriately calibrated valuation methodologies; patient-specific decisions about site of care; careful use of prior authorization; continued access to non-opioid pain management, diagnostic technologies, and other clinically valuable innovations; and

public information that is understandable and useful to patients and caregivers. Those priorities provide the framework for the NHC's review of the CY 2027 proposed rule.[1]

Several proposals in the CY 2027 rule may interact in ways that may not be evident when each is assessed independently. CMS proposes a 2.4 percent OPPS update and a 2.4 percent ASC update for facilities meeting applicable quality reporting requirements. The agency also proses new acquisition-cost-based payment methodology for 340B-acquired drugs and a substantially larger prospective reduction associated with the prior 340B remedy. Other proposed changes include continuing implementation of the phaseout of the inpatient-only (IPO) list and corresponding expansion of the ASC Covered Procedures List (CPL); a new site-of-service payment policy for imaging without contrast in excepted off-campus provider-based departments; expanded prior authorization for additional botulinum toxin injection codes; and an interim payment framework for Software as a Medical Service (SaMS). The rule also includes changes and requests for information affecting quality reporting, advance care planning, and hospital price transparency.[2]

Accordingly, the NHC encourages CMS to evaluate the CY 2027 policies at both the aggregate and patient-care levels. CMS should consider the expenditure and budget-neutrality analyses applicable to OPPS and ASC payment while also assessing whether their combined effects preserve timely access to clinically appropriate care, support meaningful patient and clinician choice regarding site of service, and provide sufficient predictability for hospitals, ASCs, and other affected organizations to adapt without disrupting established care. Where CMS is undertaking substantial changes to longstanding payment methodologies, the NHC further encourages the agency to provide disaggregated impact analyses, reasonable transition periods, clearly defined access measures, and mechanisms for reassessment if real-world experience indicates that a technically sound methodology is producing unintended consequences for patients.[3]

Summary of Recommendations

- **Payment stability and cumulative impact.** Evaluate the combined effect of the OPPS update, APC and wage-index changes, the 340B acquisition-cost adjustment, the accelerated 340B remedy offset, site-of-service policies, and other budget-neutral adjustments at the hospital, service-line, and patient-

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[1] National Health Council, "NHC Comments RE CY 2026 OPPS & ASC Proposed Rule," September 15, 2025, 5–8, 12–15, https://nationalhealthcouncil.org/wp-content/uploads/2025/09/NHC-Comments-RE-CY-2026-OPPS-Proposed-Rule_091525.pdf.

[2] Centers for Medicare & Medicaid Services, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data; Prior Authorization; Accrediting Organization Deeming for Emergency Medical Treatment and Labor Act; and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots [CMS-1850-P]," 91 Fed. Reg. 41734, 41734–37 (July 7, 2026).

[3] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41737–38, 42011–18.

population levels; and publish disaggregated impact information. Use transitional protections where abrupt reductions could jeopardize access.

- **340B-acquired drugs and the 340B remedy.** Implement acquisition-cost-based payment in a manner that is transparent, methodologically robust, and attentive to the role that affected hospitals play in caring for patients with complex and chronic conditions. Closely monitor how the proposed average sales price (ASP) minus 33.4 percent rate and the concurrent increase in the remedy offset from 0.5 percent to 3 percent impact patients. This monitoring should examine service availability; access to infusion services and specialty drugs; hospitals' capacity to provide financial assistance and navigation services; and the extent to which 340B participation produces demonstrable patient benefit.

- **Site-of-service payment and off-campus departments.** Support payment alignment where services are genuinely comparable across settings but use service-specific evidence and preserve exceptions where access, clinical complexity, emergency readiness, or geographic circumstances make hospital outpatient capacity important. The NHC supports continued protection for rural Sole Community Hospitals and recommends monitoring wait times, travel distance, service closures, and shifts in where care is available.

- **IPO list and ASC CPL.** Preserve the ability of clinicians, in consultation with patients and caregivers, to select the most appropriate treatment setting based on individual clinical risk, comorbidities, functional status, anesthesia needs, availability of post-procedure support, transportation, and other factors. Expansion of outpatient and ASC eligibility should create additional options instead of introducing de facto requirements to use a lower-cost setting.

- **Prior authorization for botulinum toxin injections.** Reconsider the proposed expansion unless CMS makes public the service-specific evidence of inappropriate utilization supporting additional codes and demonstrates that prior authorization is the least burdensome effective tool. If the proposal is finalized, include expedited review; robust continuation-of-care protections for patients receiving established treatment; streamlined renewals; transparent denial reasons, provider exemptions based on demonstrated approval performance; and public reporting on review times, denials, appeal overturns, and effects on patient access.

- **Drugs, devices, radiopharmaceuticals, and non-opioid pain management.** Maintain predictable pass-through and separate-payment pathways for innovative products, closely monitor the effect of packaging thresholds on access, continue separate payment for higher-cost diagnostic radiopharmaceuticals, and preserve payment policies that remove disincentives to evidence-based non-opioid pain management.

- **Software as a Medical Service (SaMS).** Use the proposed interim SaMS framework as a bridge to a transparent, evidence-based long-term methodology that recognizes clinical value and real-world performance without relying on

pricing arrangements that are not sufficiently transparent or comparable for Medicare payment purposes. Preserve clinician accountability, transparency to patients, accessibility, privacy and security, and meaningful patient choice. Ensure that evidence of value includes patient outcomes and experience rather than utilization or efficiency alone.

- **Quality reporting and advance care planning.** Support removal of measures that primarily capture documentation when stronger patient-outcome measures are available, and streamline validation when doing so does not weaken data integrity. Develop any outpatient advance care planning measure with patients and caregivers so that it supports voluntary, preference-sensitive conversations rather than becoming a check-box documentation requirement.

- **Hospital price transparency.** Strengthen standardization and comparability of machine-readable data while preserving a patient-facing focus on expected out-of-pocket cost, understandable descriptions of services, bundled and ancillary charges, and usable consumer tools. Any changes how estimator tools may satisfy price transparency requirements should be driven by whether they provide patients with accurate and actionable information, not simply by whether a particular reporting approach is easier to administer.

- **Behavioral health, provider-based requirements, Emergency Medical Treatment and Labor Act (EMTALA) oversight, and supply resilience.** Implement these policies with clear operational guidance, reasonable transition periods, and patient-access monitoring so that administrative compliance does not become a source of care disruption, particularly for rural, safety-net, behavioral health, and emergency-care providers.

General Comments and Patient-Centered Framework

The NHC evaluates OPPS and ASC policies through several interrelated principles: payment stability and predictability; timely access to needed care; data-driven and transparent valuation; preservation of patient and clinician choice regarding clinically appropriate site of care; sustainability of rural, safety-net, and other essential access providers; integration of physical, behavioral, and social care; and meaningful patient and caregiver engagement. These principles are consistent with the NHC's recent comments on both the Physician Fee Schedule (PFS) and OPPS, which have emphasized that changes to Medicare payment methodology should be assessed based on their effects on access, affordability, clinical appropriateness, continuity, and outcomes in addition to the technical consistency of the underlying payment system.[4]

Aggregate payment estimates can obscure substantial variation in how OPPS and ASC policies affect individual hospitals, service lines, geographic areas, and patient populations. For Medicare beneficiaries with chronic, disabling, rare, or complex conditions who rely on repeated interactions with hospital outpatient departments, specialty clinics, infusion services, diagnostic facilities, and ambulatory surgery centers,

[4] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 2–4.

the practical consequences may include longer waits, greater travel, loss of a locally available service, disruption of an established treatment pathway, or movement of care to a setting that is less appropriate for the patient's clinical or recovery needs. These effects may be concentrated among patients who already face transportation challenges, caregiver constraints, limited specialist availability, or other barriers that may be obscured when effects are assessed only at the national or aggregate level.[5,6]

Patient-access monitoring should therefore become a routine component of significant OPPS and ASC reforms and should be tailored to the policy under review rather than defined solely through changes in utilization or aggregate spending. Relevant indicators may include service volume by setting; appointment availability and wait times; travel distance; transfers, readmissions, and unplanned admissions; treatment delay or abandonment; availability of specialty drugs, diagnostics, and behavioral health services; service-line contraction or closure; and patient- and caregiver-reported barriers. Where statistically appropriate, CMS should examine these measures by geography, hospital type, service category, and clinically relevant beneficiary characteristics so that average results do not conceal substantial local or population-specific effects. The agency should also establish in advance how findings from monitoring efforts will inform implementation, including the circumstances under which CMS would issue technical guidance, extend a transition, refine an exception, modify coding or payment instructions, or address the issue in subsequent rulemaking.[7]

The technical complexity and breadth of annual OPPS and ASC rulemaking can make it difficult for patients and patient organizations to assess the practical implications of every payment methodology, APC assignment, reporting requirement, and site-of-service policy within a single notice-and-comment period. Meaningful patient engagement is therefore essential to ensuring that these policies reflect their real-world effects on patients. Structured listening sessions on major reforms, plain-language explanations of high-impact proposals, targeted engagement with affected patient communities, and public reporting on how patient and caregiver input informed final policies would improve both policy development and implementation. Claims, cost, and utilization data remain essential, but they cannot fully capture treatment burden, caregiver constraints, difficulties obtaining appointments, disruptions in established care relationships, or why a technically available service may remain inaccessible in practice.[8]

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[5] Danielle C. Lavallee et al., "Incorporating Patient-Reported Outcomes into Health Care to Engage Patients and Enhance Care," *Health Affairs* 35, no. 4 (2016): 575–82, https://doi.org/10.1377/hlthaff.2015.1362.

[6] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 5–7.

[7] National Minority Quality Forum, *Annual Report 2024*(2025), 30, https://nmqf.org/wp-content/uploads/2025/10/NMQF_AnnualReport2024-final.pdf.

[8] Council of Medical Specialty Societies and National Health Council, *Enhancing Patient Partnerships: How Patient Organizations and Medical Societies Can Enhance Patient Engagement in Clinical Registries and Research*(2020), 4, 7–10, https://cmss.org/wp-content/uploads/2020/04/CMSS-NHC-Patient-Primer-Pt.-Engagement-in-Registries-FINAL.pdf.

OPPS and ASC Payment Updates, Stability, and Cumulative Effects

For CY 2027, CMS proposes an OPD fee schedule increase factor of 2.4 percent, based on a 3.2 percent inpatient hospital market basket update reduced by a 0.8 percentage point productivity adjustment. CMS similarly proposes a 2.4 percent update for ASCs that meet quality reporting requirements. The NHC supports the objective of predictable annual payment updates and appreciates the continuation of the hospital market basket methodology for the ASC payment system through CY 2027. Outpatient facilities must plan staffing, technology acquisition, contracted services, and service-line capacity well before the beginning of a payment year making predictable annual payment updates especially important.[9]

However, the headline update does not by itself describe the financial effect of the rule on an individual hospital, ASC, or patient-critical service. CMS' own payment methodology incorporates wage-index changes, APC recalibration, outlier policies, pass-through spending adjustments, cancer hospital and rural adjustments, the proposed acquisition-cost adjustment for 340B drugs, and the separate 340B remedy offset. In addition, the rule would create a new site-of-service payment adjustment for imaging without contrast and materially change the relationship between OPPS and ASC payment for device-intensive services. The NHC therefore recommends that CMS present these policies not only as discrete technical changes but also through a cumulative impact analysis.[10]

At a minimum, CMS should publish tables showing the combined effect of the major payment changes by hospital type, geography, and service category, with particular attention to rural hospitals, safety-net hospitals, cancer centers, facilities serving high shares of Medicaid or dual-eligible patients, and facilities that furnish a disproportionate volume of specialty outpatient services. Service-level analyses are important because hospital-wide averages can conceal a reduction that is concentrated in one high-cost clinical area. When a service is clinically important to people with serious or chronic conditions and alternatives are limited, a sharp payment reduction can have significant implications for access even if the hospital's aggregate Medicare revenue rises.[11]

The NHC also encourages CMS to establish a clear process for mid-course correction. Payment systems necessarily rely on historical claims and cost data, but those data cannot fully predict how providers will respond to a new policy. CMS should identify a set of access indicators before implementation and specify how it would respond if those indicators show substantial disruption, such as a significant contraction in service availability, increased beneficiary travel, abnormal delays, or migration to settings that are less appropriate for clinically complex patients. Options could include temporary

[9] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41736–38.

[10] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41737–38, 42011–18.

[11] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41737–38, 42011–18.

transitional payments, modification of thresholds, targeted exceptions, or adjustments in future quarterly or annual rulemaking.[12]

This approach is consistent with the NHC's longstanding view that abrupt or poorly calibrated payment changes can have real consequences for patients and that technically sound valuation should be paired with transparent, auditable data and site-appropriate adjustments. It also reflects a broader principle that Medicare payment policy should not leave clinicians and patients to address the consequences of payment distortions only after a service line has become financially unsustainable.[13]

340B-Acquired Drug Payment and the Prospective Remedy Offset

The proposed 340B policies are among the most consequential changes in the CY 2027 rule. Based on the 2026 OPPS Drug Acquisition Cost Survey, CMS proposes to pay for 340B-acquired drugs at ASP minus 33.4 percent. Because the acquisition-cost-based drug payment policy is required to be budget neutral within OPPS, CMS estimates an 8.44 percent upward adjustment to non-drug OPPS payment rates. Separately, CMS proposes to accelerate the prospective adjustment used to recoup the additional non-drug payments made during CYs 2018 through 2022 under the prior 340B payment policy by increasing the annual reduction from 0.5 percent to 3 percent for affected hospitals.[14]

The NHC recognizes CMS' obligation to use acquisition-cost information where the statute directs the agency to do so and appreciates the value of empirical data over assumptions. At the same time, acquisition cost is not the only factor relevant to patient access. Hospital outpatient drug services depend on pharmacy operations, drug handling, clinical staff, infusion infrastructure, prior authorization and financial-navigation support, care coordination, and specialized services for patients with complex and resource-intensive care needs. A drug payment methodology can therefore be accurate with respect to the purchase price of a product and still have broader consequences for a hospital's ability to sustain the service in which that product is delivered.[15,16]

The proposed rule indicates that CMS believes the survey results for 340B-acquired drugs provide a statistically reliable estimate of acquisition costs. The NHC recommends that CMS continue to be transparent about the survey's representativeness, response patterns, weighting approach, treatment of outliers, and variation across hospital categories. The agency should also publish enough methodological detail for stakeholders to understand whether the proposed aggregate

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[12] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 2–4.

[13] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 2–4.

[14] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41887–95.

[15] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41887–95.

[16] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 12–14.

rate reasonably reflects the range of circumstances in which 340B drugs are furnished. Where meaningful variation exists, CMS should assess whether a single aggregate adjustment creates disproportionate effects for particular classes of providers or services.[17]

The NHC also believes that evaluation of the policy should include transparency regarding how 340B participation benefits patients and the communities served by participating hospitals. As CMS assesses the effects of the proposed payment methodology, the agency should consider whether payment changes affect access to patient-facing services as well as whether the benefits associated with 340B participation are demonstrably supporting patients through reduced financial barriers, access to needed services, or other meaningful forms of assistance. This balanced approach would allow CMS to evaluate the policy based on its actual effects on patients rather than assuming that existing payment differentials necessarily translate into patient benefit or that reducing those differentials will have no impact on access.[18,19,20]

CMS should also evaluate the acquisition-cost change together with the accelerated remedy offset rather than treating them as independent policies. For affected hospitals, the 3 percent prospective reduction to non-drug items and services will operate at the same time that drug payment is recalibrated to the new acquisition-cost rate and other OPPS changes take effect. The combined effect may differ significantly across hospitals depending on their drug mix, service mix, 340B participation, and dependence on hospital outpatient revenue. The NHC recommends a combined impact analysis and a transition strategy for circumstances in which the simultaneous adjustments create a material risk to patient-critical services.[21]

Patient-centered monitoring should focus on outcomes that matter in practice. CMS should examine whether affected hospitals reduce or discontinue infusion services, oncology services, specialty pharmacy support, medication navigation, transportation assistance, uncompensated or subsidized care, or other outpatient programs relied upon by patients with chronic or complex conditions. The agency should also monitor whether patients experience longer scheduling delays, increased travel, treatment interruptions, or higher rates of referral to alternative settings. This monitoring is not

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[17] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41887–95.

[18] Arthritis Foundation and Lupus Foundation of America, *Impact of the 340B Program on Rheumatoid Arthritis and Lupus Therapies: Summary of Research* (Spring 2025), https://www.lupus.org/sites/default/files/media/documents/340BResearch%20Summary%20July2025%20FINAL%28forweb%29.pdf.

[19] Biotechnology Innovation Organization, “BIO Statement to the Senate 340B Bipartisan Working Group on Safeguarding and Strengthening 340B,” April 1, 2024, 1–2, https://www.bio.org/sites/default/files/2024-04/senate_340b_rfi_final.pdf.

[20] Pharmaceutical Research and Manufacturers of America, *Comments on Senate 340B RFI*, July 28, 2023, 16–17, https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Policy-Papers/PhRMA-Comments---6162023-Senate-RFI-on-340B---072823.pdf.

[21] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41887–95.

intended to preserve any particular payment differential regardless of evidence. Rather, it would provide safeguards to ensure that implementation of an acquisition-cost methodology does not produce unintended barriers to access.[22]

The NHC further encourages CMS to establish a regular public reporting mechanism during the first two years of implementation. Aggregate reporting could include changes in relevant outpatient service volumes, hospital participation in affected service lines, beneficiary travel patterns, and other available indicators. Where the data identify a meaningful access problem, CMS should be prepared to use its existing authorities where available to refine implementation or recommend legislative changes if statutory constraints prevent an appropriate response. A transparent feedback loop would strengthen confidence that the policy is being evaluated on both fiscal and patient-centered grounds.[23,24]

Site-of-Service Payment for Off-Campus Imaging Without Contrast

CMS proposes to apply a PFS-equivalent payment rate to imaging without contrast services furnished by excepted off-campus provider-based departments, using its authority to control unnecessary increases in the volume of covered outpatient department services. CMS proposes to exempt rural Sole Community Hospitals from this policy. The proposal builds on prior site-of-service policies for clinic visits and drug administration and reflects CMS' concern that payment differentials can create incentives to furnish certain low- or moderate-complexity services in the higher-paid hospital outpatient setting.[25]

The NHC supports efforts to reduce payment differences that are not justified by meaningful differences in the service furnished to a patient. Patients and the Medicare program should not pay more solely because a service has migrated to a different ownership structure or billing designation when the clinical service, safety requirements, and resources used are substantially equivalent. At the same time, site-neutral payment should not rest on the presumption that all settings are interchangeable. Hospital outpatient departments may serve more clinically complex patients, maintain capabilities that are not readily available in freestanding settings, and operate in communities where alternatives are limited. These differences should be evaluated with service-specific evidence rather than assumed away. The NHC's objective is not to preserve payment differentials where comparable care can safely and effectively be

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[22] Arthritis Foundation and Lupus Foundation of America, *Impact of the 340B Program on Rheumatoid Arthritis and Lupus Therapies*.

[23] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41887–95.

[24] Medicare Payment Advisory Commission, *Report to the Congress: Overview of the 340B Drug Pricing Program* (Washington, DC: MedPAC, May 2015), https://www.medpac.gov/document/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program/.

[25] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41898–41904.

furnished at lower cost. Rather, payment alignment should not treat clinically or geographically distinct settings as interchangeable when they are not.[26,27]

For imaging without contrast, the NHC recommends that CMS finalize any payment alignment only with strong access monitoring and clear criteria for exceptions. The agency should track whether the policy changes the availability of imaging in rural and underserved areas, whether patients must travel farther or wait longer, and whether hospitals reduce access to imaging that supports emergency, oncology, musculoskeletal, neurologic, or other longitudinal care. The agency should also evaluate whether payment reductions have different implications when imaging capacity is integrated into a specialty clinic or hospital service line that serves medically complex beneficiaries.[28]

The NHC supports the proposed exemption for rural Sole Community Hospitals because the absence of a realistic alternative site of care can make an otherwise modest payment adjustment consequential for access. The NHC also encourages CMS to consider whether data support targeted protections for other facilities that function as essential access points, including certain safety-net or geographically isolated providers, rather than relying solely on formal hospital classification. Any broader exception should be carefully defined and tied to demonstrated access need so that it does not recreate unjustified payment differences where meaningful competition and alternative capacity exist.[29]

CMS should also be explicit that site-of-service payment policy does not change the underlying clinical principle that the appropriate setting depends on the individual patient. Payment alignment should reduce financial incentives to choose one setting over another, not create a new incentive to redirect care away from hospital outpatient departments when the patient's comorbidities, disability, need for coordinated services, or other circumstances make that setting clinically preferable.[30]

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

[27] AHIP, "Comments on CY 2026 OPPS Proposed Rule," September 12, 2025, 13, https://downloads.regulations.gov/CMS-2025-0306-2204/attachment_1.pdf.

[28] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 5–7.

[29] 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.

[30] Immune Deficiency Foundation, "Clinical Update in Immunoglobulin Therapy for Primary Immunodeficiency Diseases," *Clinical Focus*, issue 14 (March 2011): 6, https://primaryimmune.org/sites/default/files/Clinical-Focus-Clinical-Update-in-Immunoglobulin-Therapy-for-PI.pdf.

Phaseout of the Inpatient-Only List and Expansion of the ASC Covered Procedures List

For CY 2027, CMS proposes to continue the three-year phaseout of the IPO list by removing 638 services across multiple clinical families and to add 618 codes to the ASC CPL based on stakeholder recommendations or proposed removal from the IPO list. These changes would substantially expand the range of procedures that Medicare may pay for in outpatient hospital and ASC settings. The NHC has previously supported greater flexibility in where patients can receive care while emphasizing that removal from the IPO list should create an option, not a requirement, and that the final site-of-care decision should remain individualized.[31,32]

That principle becomes increasingly important as the list of outpatient-eligible procedures grows beyond relatively straightforward services. CMS has historically recognized that physicians and hospitals must exercise professional judgment and assess the risk of a procedure to the individual patient, taking the site of service into account. The NHC strongly supports maintaining this patient-by-patient framework. A procedure may be safe in an outpatient or ASC setting for many beneficiaries while remaining inappropriate for an older adult with multiple chronic conditions, significant functional limitations, frailty, complex medication needs, or inadequate support after discharge.[33,34]

Clinical risk is only part of the decision. Patients recovering from anesthesia or a significant procedure may need reliable transportation, caregiver support, access to home health or rehabilitation, and the ability to return quickly if complications occur. These factors are not consistently visible in claims data, yet they influence whether an outpatient pathway is safe and workable. The NHC therefore recommends that CMS develop patient-facing and clinician-facing guidance emphasizing that eligibility for outpatient payment does not supersede individualized assessment of clinical and nonclinical recovery needs.[35,36]

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[31] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41883–86, 41915–20.

[32] National Health Council, “Comments on Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs [CMS-1736-P],” October 5, 2020, 2–3.

[33] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41883–86, 41915–20.

[34] Jeffrey H. Silber et al., “The Safety of Performing Surgery at Ambulatory Surgery Centers versus Hospital Outpatient Departments in Older Patients with or without Multimorbidity,” *Medical Care* 61, no. 5 (2023): 328–37, https://doi.org/10.1097/MLR.0000000000001836.

[35] Niraja Rajan, Eric B. Rosero, and Girish P. Joshi, “Patient Selection for Adult Ambulatory Surgery: A Narrative Review,” *Anesthesia & Analgesia* 133, no. 6 (2021): 1415–30, https://doi.org/10.1213/ANE.0000000000005605.

[36] National Alliance for Caregiving, *2026 Policy Agenda*(2026), 4, https://www.caregiving.org/wp-content/uploads/2026/03/NAC_2026_PolicyAgenda_FINAL.pdf.

CMS should also monitor the consequences of removing large numbers of procedures from the IPO list. Relevant indicators include unplanned admissions, emergency department visits, transfers from ASCs, readmissions, postoperative complications, changes in observation use, and patient- and caregiver-reported recovery burden. Results should be examined by procedure and patient risk profile rather than only in aggregate. Where a procedure shows a pattern of adverse outcomes or substantial access barriers in a lower-acuity setting, CMS should be willing to revisit its status or provide additional safeguards.[37]

The same principle applies to expansion of the ASC CPL. ASCs can provide high-quality, efficient care and may offer patients more convenient access for appropriate procedures, but the payment system should not create pressure to use an ASC when a hospital outpatient department is more appropriate. Medicare Advantage plans and other payers should likewise ensure that site-of-care utilization management preserves access to the hospital outpatient setting when individual clinical circumstances make that setting appropriate. They should also provide timely, clinically appropriate exception processes when standard site-of-care policies do not reflect a patient's needs. The NHC raised this concern in our 2020 OPPS comments and believes it remains relevant as the range of ASC-eligible procedures expands.[38]

Finally, CMS should ensure that beneficiaries understand the implications of the site in which a procedure is performed, including expected cost sharing, facility capabilities, postoperative support, and what happens if an unplanned transfer or admission becomes necessary. Greater site-of-care choice is beneficial only when it is accompanied by information and safeguards that allow patients and caregivers to make meaningful decisions.[39]

Expansion of Prior Authorization for Botulinum Toxin Injection Services

CMS proposes adding eight additional botulinum toxin injection codes to the existing hospital outpatient department prior authorization program for dates of service on or after July 1, 2027. The NHC recognizes the importance of program integrity and the need to address services that are demonstrably vulnerable to unnecessary utilization. However, we have consistently urged CMS to set a high bar before adding services to

[37] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41883–86, 41915–20.

[38] Silber et al., "Safety of Performing Surgery at Ambulatory Surgery Centers," 328–37.

[39] Rajan, Rosero, and Joshi, "Patient Selection for Adult Ambulatory Surgery," 1415–30.

prior authorization because the administrative mechanism itself can delay or disrupt medically necessary care.[40,41,42]

The patient implications depend heavily on how the newly included codes are used in clinical practice and whether prior authorization can distinguish inappropriate utilization from legitimate treatment without creating avoidable delay. Botulinum toxin injections are used in a range of therapeutic contexts, including for patients who may rely on scheduled, recurring treatment to maintain function or control symptoms. A utilization-management policy that repeatedly re-adjudicates an established course of therapy can impose burden without meaningfully improving program integrity. The NHC therefore recommends that CMS make public the service-specific utilization evidence supporting each additional code and explain why prior authorization is the least burdensome effective tool.[43,44,45]

If CMS finalizes the expansion, the program should incorporate robust continuation-of-care protections. Patients who are stable on an established regimen should not be forced through the same documentation process at every treatment cycle unless there is a meaningful change in clinical circumstances. CMS should consider streamlined renewals, longer authorization periods where clinically appropriate, and simplified continuation-of-care pathways when the patient has met established criteria and the treating clinician documents ongoing benefit. These protections would reduce administrative burden for both patients and providers while allowing CMS to focus review resources on cases representing a genuine program-integrity concern.[46,47]

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[40] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41975–78.

[41] Alliance for Aging Research, "Alliance Comments: Proposed Rule on Interoperability Standards and Prior Authorization for Drugs Is Promising, but Needs Greater Oversight," June 11, 2026, https://www.agingresearch.org/news/alliance-comments-proposed-rule-on-interoperability-standards-and-prior-authorization-for-drugs-is-promising-but-needs-greater-oversight/.

[42] Pharmaceutical Research and Manufacturers of America, "Americans Speak Out on Health Insurance Barriers and Need for Policy Change, According to the Latest Patient Experience Survey," October 28, 2024, https://phrma.org/blog/patient-experience-survey-americans-speak-out-on-health-insurance-barriers-and-need-for-policy-change.

[43] Arthritis Foundation, *Utilization Management, Insurance Barriers Survey & Focus Group Findings 2024* (2024), 5–7, https://www.arthritis.org/getmedia/c276e8b0-b915-46cd-85cc-37dd41201de8/2024_UM_and_Insurance_Barriers_Report_8-5x11__1_.pdf.

[44] Crohn's & Colitis Foundation, "Removing Obstacles to Treatment," *Impact Report*, Summer 2022, https://www.crohnscolitisfoundation.org/impact-report-summer-2022.

[45] Epilepsy Foundation of America, *Access to Care Survey* (June 2020), 8, 11, https://www.epilepsy.com/sites/default/files/atoms/files/Access%20to%20Care%20Survey%20-%202020%20-%20FINAL%2008.12.20.pdf.

[46] Arthritis Foundation, *Utilization Management, Insurance Barriers*, 5–7.

[47] National Psoriasis Foundation, "National Psoriasis Foundation Applauds Congressional Leaders for Introducing the 'Safe Step Act' and Calls for Swift Passage to Protect Millions of Patients," September 19, 2025, https://www.psoriasis.org/safe-step-act-press-release/.

Prior authorization processes must also be timely and transparent. The NHC's recent comments on interoperability and prior authorization emphasized that reform should be judged by whether it improves timely access to medically necessary care in practice, not simply whether an administrative transaction is completed electronically. Denial communications should be specific enough to support prompt correction or appeal, and expedited review should be available when delay may lead to loss of function, worsening symptoms, or other meaningful harm. CMS should also minimize duplicative requests for documentation already available in the record.[48,49]

CMS should also use its existing authority to exempt providers with consistently high approval rates and low error rates, with safeguards against arbitrary removal from the exemption. This targeted approach allows the agency to focus on outlier utilization while reducing burden for providers that demonstrate appropriate billing patterns. Public reporting should include authorization volume, approval and denial rates, decision times, rates of resubmission and appeal, overturn rates, and any measurable changes in utilization or access after implementation.[50]

More broadly, the NHC encourages CMS to use this expansion as an opportunity to establish a consistent patient-centered standard for fee-for-service prior authorization. Prior authorization practices must be narrowly targeted, evidence based, operationally efficient, transparent, and paired with an explicit process for determining whether thy are causing unintended patient harm. If the data do not demonstrate that the added botulinum toxin codes meet that standard, CMS should not proceed simply because the administrative infrastructure already exists.[51]

Drugs, Biologicals, Radiopharmaceuticals, Devices, and Non-Opioid Pain Management

OPPS policy for drugs, biologicals, radiopharmaceuticals, and devices directly affects whether outpatient facilities can adopt new technologies and maintain access to high-cost or specialized treatments. The NHC has repeatedly emphasized the importance of predictable pass-through and separate-payment pathways because abrupt movement from separate payment into a packaged APC can change the economics of furnishing a therapy before providers and patients have had adequate time to adapt. These effects may be especially significant in oncology, neurology, rare disease, imaging, and other

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[48] Michael A. Kyle and Austin B. Frakt, "Patient Administrative Burden in the US Health Care System," *Health Services Research* 56, no. 5 (2021): 755–65, https://doi.org/10.1111/1475-6773.13861.

[49] Arthritis Foundation, *Utilization Management, Insurance Barriers*, 5–7.

[50] Council of Medical Specialty Societies, "CMSS Principles for Increasing Access to Needed Medications by Patients 2016," January 10, 2016, https://cmss.org/statements/cmss-principles-for-increasing-access-to-needed-medications-by-patients-2016/.

[51] Kyle and Frakt, "Patient Administrative Burden," 755–65.

areas in which a product may have limited substitutes or be essential to a diagnostic or treatment pathway.[52]

For diagnostic radiopharmaceuticals, CMS proposes to increase the packaging threshold from $630 to $665 per day for CY 2027 and to continue separate payment above that threshold based on arithmetic mean unit cost using hospital claims data, while continuing to encourage voluntary ASP reporting. The NHC supports the continuation of separate payment for higher-cost diagnostic radiopharmaceuticals. Our 2023 OPPS comments specifically raised concerns that broad packaging can limit access to important diagnostic technologies and supported alternative payment mechanisms that reduce the risk that hospitals will avoid newer or more expensive products solely because the packaged payment is insufficient.[53,54]

CMS should continue to evaluate whether the threshold methodology keeps pace with the clinical and economic realities of diagnostic radiopharmaceuticals. A threshold can provide administrative simplicity, but it also creates a cliff where a relatively small difference in calculated per-day cost can determine whether a product is paid separately. The NHC recommends that CMS monitor utilization by product and facility after each annual threshold update and assess whether products near the threshold show unusual changes in availability. Where new products lack claims data, the temporary hierarchy using ASP, wholesale acquisition cost, or other available benchmarks should be implemented transparently and updated promptly as better data become available.[55]

The NHC similarly supports continued attention to pass-through transitions for devices and drugs. CMS proposes to approve some new device pass-through applications and deny others, as it does annually. In each case, the agency should ensure that criteria and timelines are predictable and that expiration of pass-through status does not unexpectedly make clinically valuable technology unavailable. For products used by small patient populations or in specialized centers, claims data may mature slowly. CMS should take the resulting limitations in claims data into account when determining whether an APC has sufficient information to absorb the cost of the technology without creating access problems.[56]

The rule also continues separate payment for qualifying non-opioid pain management drugs and devices. The NHC has supported this policy direction since our 2018 OPPS comments, where we raised concerns that bundled payment could discourage use of

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[52] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 12–14.

[53] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41746–48, 41861–69.

[54] National Health Council, “NHC Comments on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems,” 2023, 2–3, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment-systems/.

[55] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41746–48, 41861–69.

[56] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 12–14.

clinically appropriate non-opioid alternatives. Medicare payment policy should adequately recognize the distinct acquisition costs of these alternatives so that payment does not inadvertently favor opioid treatments over clinically appropriate non-opioid options. CMS should continue to assess whether current eligibility criteria capture meaningful non-opioid alternatives and whether utilization data show that separate payment is improving access without encouraging inappropriate use.[57,58]

Across these policies, the NHC recommends a common patient-centered approach: separate payment should be available where packaging would predictably create an access barrier; packaging should be used where the cost can reasonably be absorbed without changing treatment choice; and transitions between the two should be transparent enough that providers can plan and patients do not experience abrupt disruptions in care. CMS should also continue to engage patient organizations when payment changes affect technologies that are used primarily in specific disease areas, because utilization data alone may not reveal the clinical consequences of losing access to a particular diagnostic or treatment option.[59]

Software as a Medical Service (SaMS)

CMS proposes replacing Software as a Service with Software as a Medical Service (SaMS) for purposes of OPPS payment policy and establishing an interim methodology that assigns separately paid SaMS technologies to New Technology APCs. CMS also proposes implementing a new status indicator, O1, for SaMS that is separately paid under the OPPS, and moving 21 HCPCS codes from clinical APCs to New Technology APCs while generally maintaining approximate payment continuity. The NHC supports the agency's effort to bring greater consistency and transparency to a rapidly evolving category that does not fit neatly into payment systems designed around material inputs.[60]

A temporary framework is reasonable while CMS develops a more durable methodology, but the long-term solution should not rely solely on acquisition price, licensing arrangements, or the fact that a technology has a distinct code. Software can have relatively low marginal cost once deployed while still requiring substantial investment in development, validation, implementation, cybersecurity, integration, and clinical workflow. A high license price is not itself evidence of greater clinical value. CMS will therefore need a valuation framework that recognizes both efficiencies created by technology and the clinical responsibilities associated with its use. This includes interpreting outputs, integrating them into care, maintaining clinical accountability, and

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[57] National Health Council, "Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs," September 26, 2018, 3–4, https://nationalhealthcouncil.org/letters-comments/public-policy-letters-comments-nhc-comments-medicare-program-proposed-changes-hospital-outpatient/.

[58] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41878–83.

[59] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 13–14.

[60] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41803–8, 41919–26.

responding when the technology generates additional testing, follow-up, or other downstream work.[61]

Evidence used to value SaMS should examine how the technology affects care in practice and should include analytical and clinical validation, real-world performance, clinical outcomes, patient experience, safety, access, and treatment burden in addition to measures of utilization or efficiency. The framework should also consider performance across patient populations and care settings, the relevance of the output to clinical decision-making, and whether the technology meaningfully improves outcomes or care processes. Medicare should avoid inadvertently rewarding tools that perform well only in the population on which an algorithm was originally developed or that shift rather than reduce the work required to care for patients.[62]

Several patient protections should also inform the longer-term SaMS framework: Patients should receive meaningful information when a software or algorithmic tool is materially involved in generating information or recommendations used in their care. An accountable clinician should remain available when human judgment is necessary. Tools and workflows should be accessible to people with disabilities, limited English proficiency, low digital literacy, or limited technology access. Payment arrangements should not create incentives to substitute automated interactions for clinically necessary human care solely because the automated pathway is less expensive. CMS does not need to require disclosure of proprietary source code to expect meaningful information about intended use, validation, known limitations, version changes, and performance. When a software update materially changes functionality, the agency should consider whether payment status and evidence expectations should also be revisited.[63]

The NHC also recommends patient and caregiver engagement as CMS develops the longer-term framework. Patients can help identify outcomes that matter, usability issues, accessibility barriers, and circumstances in which algorithmic recommendations may create confusion or add burden. This is particularly relevant for technologies used in diagnostic pathways where a false positive, false negative, or poorly communicated risk score can trigger additional testing, anxiety, cost, or delay. Patient engagement should be incorporated early enough to shape the framework rather than used only to validate a methodology after its core assumptions have been set.[64,65]

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[61] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41803–8, 41919–26.

[62] U.S. Food and Drug Administration, “Transparency for Machine Learning-Enabled Medical Devices: Guiding Principles,” June 2024, https://www.fda.gov/medical-devices/software-medical-device-samd/transparency-machine-learning-enabled-medical-devices-guiding-principles.

[63] FDA, “Transparency for Machine Learning-Enabled Medical Devices.”

[64] National Health Council, *The National Health Council Rubric to Capture the Patient Voice: A Guide to Incorporating the Patient Voice into the Health Ecosystem* (Washington, DC: National Health Council, June 2019), https://nationalhealthcouncil.org/wp-content/uploads/2019/12/NHC_Patient_Engagement_Rubric.pdf.

[65] FDA, “Transparency for Machine Learning-Enabled Medical Devices.”

For CY 2027, the proposed New Technology APC approach and O1 status indicator can provide a useful bridge, provided CMS closely monitors payment variation, utilization, and clinical outcomes and makes clear that the interim methodology does not prejudge the long-term valuation of SaMS. The NHC encourages CMS to publish a roadmap for the evidence and data it will collect during the interim period and to explain how those data will inform future rulemaking.[66]

Hospital Outpatient and ASC Quality Reporting Programs

CMS proposes to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from both the Hospital Outpatient Quality Reporting (OQR) and ASC Quality Reporting (ASCQR) Programs beginning with the CY 2027 reporting period/CY 2029 payment determination. CMS explains that the measure primarily assesses documentation of a recommended follow-up interval rather than whether the patient ultimately receives appropriate follow-up care. Both programs will retain a Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure that is more directly tied to patient outcomes. The NHC supports removal of measures that add reporting burden without providing distinct, patient-relevant information, particularly where a stronger outcome-oriented measure addresses the same clinical area.[67]

The NHC has consistently encouraged CMS to focus quality programs on outcomes and experiences that matter to patients rather than process measures that can become detached from actual care. Documentation is important when it supports communication and continuity, but a measure that rewards documentation without assessing whether appropriate follow-up occurs may have limited value for patients. CMS should continue to maintain appropriate colorectal cancer screening measures in other programs and monitor whether removal of the documentation measure affects clinical practice in any unexpected ways.[68]

The proposed refinements to OQR validation also appear reasonable. CMS proposes to incorporate electronic clinical quality measures into the existing validation process, reduce the validation selection pool, lower the number of cases required for validation, extend the validation cycle, and eliminate the requirement that hospitals resubmit medical documentation as part of a reconsideration request. The NHC supports reducing duplicative administrative burden when possible without compromising data integrity. The agency should ensure, however, that changes in validation do not create systematic differences in data reliability across hospitals with different electronic health record (EHR) capabilities or resource levels.[69]

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[66] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41803–8, 41919–26.

[67] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41957–67.

[68] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 7–8.

[69] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41957–67.

For ASCs, CMS is seeking input on potential stratification of the All-Cause Transfer/Admission measure. The NHC supports exploring stratification when it improves interpretation and helps patients understand whether observed differences reflect quality, case mix, or structural access factors. Stratification should be clinically meaningful and should not obscure poor outcomes by over-adjusting for factors that are themselves related to quality. CMS should engage patients, caregivers, clinicians, and methodologists in determining which factors improve fairness and interpretability, including patient complexity, rurality, and access to hospital backup where relevant.[70]

Public reporting should remain understandable. The NHC's prior OPPS comments emphasized that patients need clear explanations of what quality measures mean and how methodological changes affect visible ratings or performance information. CMS should pair any major change to measure calculation or validation with plain-language communication so that patients, caregivers, and advocates do not interpret a methodological change as a sudden improvement or decline in actual care quality.[71]

Request for Information on an Advance Care Planning Measure

CMS is seeking input on including an Advance Care Planning electronic clinical quality measure in the Hospital OQR Program and on other quality measure concepts related to advance care planning in the hospital outpatient setting. The NHC supports the goal of ensuring that care reflects a patient's values, goals, and preferences and agrees that outpatient settings can provide repeated opportunities to initiate or update these conversations before a crisis occurs. However, advance care planning is highly preference-sensitive, and the quality of the interaction cannot be reduced to the presence of a document in the EHR.[72,73]

Any outpatient measure should preserve the voluntary, informed, and revisable nature of advance care planning. A high-quality process may result in completion of an advance directive, identification of a surrogate, clarification of treatment goals, confirmation that an existing document remains accurate, or a patient's decision to defer further discussion. Quality policy should recognize this range of appropriate outcomes and should avoid creating incentives that transform a personal conversation into a documentation exercise or pressure a patient to participate before they are ready.[74]

The NHC also encourages CMS to account for communication accessibility, supported decision-making, and caregiver involvement. Clinical teams should be able to

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[70] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41957–67.

[71] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 7–8.

[72] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41967–72.

[73] Elizabeth Weathers et al., "Advance Care Planning: A Systematic Review of Randomised Controlled Trials Conducted with Older Adults," *Maturitas* 91 (2016): 101–9, https://doi.org/10.1016/j.maturitas.2016.06.016.

[74] Weathers et al., "Advance Care Planning," 101–9.

accommodate language needs, disability-related communication requirements, and participation by family members or trusted caregivers selected by the patient, particularly when these supports are necessary for meaningful participation. Preferences can change with diagnosis, functional status, treatment experience, or personal circumstances, making periodic reassessment and portability of documented preferences across care settings are more important than a one-time completion rate.[75]

Because the measure would be implemented in outpatient settings that serve patients with very different health states, the denominator and timing deserve careful consideration. A universal adult denominator may encourage broader normalization of advance care planning, but it also risks converting a deeply personal discussion into a compliance exercise when the clinical context is not appropriate. CMS should test alternative specifications and seek direct patient and caregiver input on whether the measure feels relevant, respectful, and useful in different outpatient settings.[76,77]

The NHC recommends that CMS convene patients, caregivers, serious-illness experts, disability advocates, clinicians, health systems, and quality-methodology experts before proposing a final outpatient measure. CMS should also test whether the measure improves outcomes that patients care about, including concordance between expressed preferences and care received, confidence that clinicians understand those preferences, reduced decisional conflict, and continuity of preferences across care transitions. These outcomes are more meaningful than the mere existence of a field in the EHR.[78,79]

Hospital Price Transparency: Standardization, Comparability, and Patient Use

The CY 2027 rule requests input on ways to improve the standardization and comparability of hospital price transparency data, including reporting of complex contracting mechanisms such as outlier payments, stop-loss provisions, rate tiering, and carve-outs. CMS also seeks comment on the consumer-friendly display requirements, including whether to modify or eliminate the deemed-compliance policy for internet-based price estimator tools, whether to update the required list of shoppable services, and how ancillary and bundled services should be reflected. The NHC strongly supports the agency's continued focus on making price information more usable and comparable.[80]

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[75] Li-Shan Ke and Hui-Chuan Cheng, "Family Caregivers' Experiences and Perspectives Regarding the Implementation of Advance Care Planning among Older Adults: A Systematic Review and Meta-Synthesis," *Geriatric Nursing* 69 (2026): 103800, https://doi.org/10.1016/j.gerinurse.2026.103800.

[76] Weathers et al., "Advance Care Planning," 101–9.

[77] Ke and Cheng, "Family Caregivers' Experiences and Perspectives," 103800.

[78] Weathers et al., "Advance Care Planning," 101–9.

[79] National Health Council, *Rubric to Capture the Patient Voice.*

[80] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41982–90.

The NHC has supported hospital price transparency for years, but our position has consistently been that transparency is useful only if it helps patients answer the questions they actually face: Where can I receive the service I need, what am I likely to pay out of pocket, what related services may be billed separately, and how does the option compare with alternatives? Machine-readable files are important infrastructure for researchers, plans, employers, patient organizations, and consumer-tool developers, but the existence of a technically compliant file does not by itself make a patient more informed.[81]

To make hospital price transparency data more reliable and comparable, the NHC supports greater standardization of complex contracting methodologies. A price that excludes a known outlier mechanism, carve-out, or tiering arrangement may appear comparable when it is not. CMS should establish common definitions and data elements that allow third parties to reconstruct the logic of a negotiated price without requiring disclosure of unnecessary proprietary detail. The objective should be to reduce false comparability, not to overwhelm patients with contractual complexity. Technical information can remain in the machine-readable data, but patient-facing tools should provide clear, accessible information about what patients can expect to pay for a service or episode.[82,83]

Bundled and ancillary services require particular attention. As the NHC noted in 2019, a patient comparing the price of a colonoscopy may need to understand anesthesia, pathology, facility, and other associated charges rather than solely the price of the primary service. Similar issues arise across outpatient surgery, imaging, infusion, and diagnostic services. CMS should require consumer displays to make clear what is and is not included in an estimate, identify common additional charges, and avoid presenting a single number as a complete episode price when material components are excluded.[84]

The NHC encourages CMS to retain deemed compliance for internet-based estimator tools rather than eliminate it simply because a standardized display is administratively easier. Many patients are more likely to use an interactive estimator than a static list, particularly when the tool can incorporate plan-specific benefits and remaining deductible information. CMS should instead establish performance standards for deemed-compliant tools, including accuracy, clear identification of assumptions, accessibility for people with disabilities, understandable language, mobile usability, and

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[81] National Health Council, “Proposed Changes to the Medicare Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System,” September 27, 2019, https://nationalhealthcouncil.org/letters-comments/public-policy-letters-comments-nhc-comments-proposed-changes-medicare-outpatient-prospective-payment/.

[82] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41982–90.

[83] Centers for Medicare & Medicaid Services, *Hospital Price Transparency Frequently Asked Questions (FAQs)* (June 2026), 36–39, https://www.cms.gov/files/document/hpt-policy-faqs-june-2026.pdf.

[84] CMS, *Hospital Price Transparency Frequently Asked Questions*, 36–39.

disclosure of whether the estimate includes all common ancillary services. If a tool cannot meet those standards, deemed compliance should not apply.[85]

CMS should also consider how price information can be connected to quality information without creating false precision. Patients generally do not seek the lowest price in isolation; they seek appropriate care at a cost they can afford. Where reliable and relevant quality measures exist, consumer tools should make it possible to view price and quality together. The agency should avoid simplistic composite rankings that imply a universal best choice. The most appropriate provider may depend on clinical complexity, geographic access, network status, and patient preference.[86]

Finally, CMS should test proposed consumer-facing requirements directly with Medicare beneficiaries and caregivers before finalizing major changes. The NHC recommends structured usability testing that includes people with chronic conditions, people with disabilities, older adults, people with limited health literacy, and caregivers who frequently assist with care navigation. CMS should evaluate success by users' ability to understand their likely financial responsibility and compare realistic care options, not by whether hospitals have technically met the reporting requirements.[87]

Partial Hospitalization and Intensive Outpatient Program Payment

CMS proposes to update payment rates for Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs) using the methodology finalized for CY 2026. The NHC supports maintaining stable access to these services because behavioral health needs frequently coexist with chronic physical conditions and can determine whether patients are able to adhere to treatment, avoid hospitalization, and maintain function in the community. Medicare payment policy should support a continuum of behavioral health services that allows patients to receive intensive treatment without requiring inpatient admission when a less restrictive setting is clinically appropriate.[88,89]

As CMS continues to use the revised methodology, the agency should monitor whether payment rates sustain adequate participation among hospital-based programs and community mental health centers, particularly in areas with behavioral health workforce shortages. Payment adequacy should be evaluated not only through aggregate program spending but also through access indicators such as wait times, geographic availability,

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[85] Meagan Bechel et al., "Usability of Hospital Price Estimators for Lumbar Spine MRI," *Journal of the American College of Radiology* 19, no. 11 (2022): 1253–59, https://doi.org/10.1016/j.jacr.2022.07.012.

[86] Merina Thomas et al., "Comparison of Hospital Online Price and Telephone Price for Shoppable Services," *JAMA Internal Medicine* 183, no. 11 (2023): 1214–20, https://doi.org/10.1001/jamainternmed.2023.4753.

[87] Bechel et al., "Usability of Hospital Price Estimators," 1253–59.

[88] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41898–41905.

[89] National Alliance on Mental Illness, "NAMI 2025 State Legislation Issue Brief Series: Trends in Access to Mental Health Care State Policy," accessed August 20, 2026, https://www.nami.org/public-policy-reports/2025-state-legislation-issue-brief-series-trends-in-access-to-mental-health-care-state-policy/.

premature discharge, readmission to higher levels of care, and continuity following PHP or IOP completion. These measures can help distinguish appropriate changes in utilization from a contraction in capacity.[90]

CMS should also continue to promote coordination between behavioral health and physical health care. Many Medicare beneficiaries using PHP or IOP services also have complex medication regimens, chronic medical conditions, disability-related needs, or caregiver involvement that must be addressed for treatment to succeed. Quality and payment policies should recognize these coordination needs rather than treating behavioral health episodes as isolated from the rest of the patient's care.[91]

Implementation of New Provider-Based Requirements for Off-Campus Departments

The proposed rule would implement provisions of the Consolidated Appropriations Act, 2026, that condition Medicare payment for off-campus outpatient departments beginning in 2028 on use of separate National Provider Identifiers and provider-based attestations, with CMS responsible for reviewing attestations and verifying compliance through site visits, remote audits, or other means. These statutory requirements must be implemented with clear accountability without allowing technical or administrative failures to disrupt medically necessary care.[92]

The NHC encourages CMS to provide detailed operational guidance well in advance of the January 1, 2028 effective date, including clear timelines, examples of compliant organizational structures, instructions for existing departments, and a mechanism for correcting minor or good-faith deficiencies. Hospitals should not learn that an NPI or attestation issue has jeopardized payment only after claims have accumulated. A pre-implementation readiness process and accessible technical assistance could prevent avoidable payment interruptions that ultimately affect patients.[93]

CMS should also consider how the verification process impacts care continuity. A site visit or audit may identify a deficiency that requires remediation, but immediate cessation of payment could be disproportionate when the issue is administrative and patient care remains safe and clinically appropriate. To the extent permitted by statute, CMS should distinguish deficiencies that raise substantive concerns about provider-based status or program integrity from technical errors that can be corrected within a defined period.[94]

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[90] National Alliance on Mental Illness, "Trends in Access to Mental Health Care State Policy."

[91] 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.

[92] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41978–82.

[93] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41978–82.

[94] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41978–82.

Finally, CMS should monitor whether the new requirements lead hospitals to close or restructure off-campus departments in ways that reduce local access. The intent of stronger provider-based standards should not be undermined by implementation that unexpectedly removes a needed specialty clinic, infusion site, or diagnostic service from a community without adequate alternatives. Patient access data should therefore inform future refinements to the process.[95]

Accrediting Organization Deeming for EMTALA Administrative Requirements

CMS proposes to permit hospital accrediting organizations with deeming authority to assess compliance with certain EMTALA administrative requirements during accreditation and reaccreditation surveys. The NHC supports efforts to improve consistency and reduce unnecessary duplication in oversight when those changes maintain clear federal accountability and do not weaken protections for patients seeking emergency care.[96]

Implementation should focus on administrative requirements that accrediting organizations can reliably and consistently evaluate. CMS should provide standardized interpretive guidance, surveyor training expectations, and clear escalation pathways for issues that may indicate a substantive EMTALA violation. Hospitals should receive consistent information about what is expected regardless of accrediting organization, and CMS should periodically assess inter-rater reliability and patterns of findings across organizations.[97]

Most importantly, the oversight model should remain anchored in the patient purpose of EMTALA: people seeking emergency evaluation and stabilizing treatment should not face inappropriate delay or denial because of payment status, administrative complexity, or uncertainty about hospital obligations. CMS should monitor whether the new deeming approach changes complaint patterns, investigation timelines, or the consistency of enforcement and should be prepared to refine the policy if administrative streamlining reduces visibility into patient-facing problems.[98]

Domestic Procurement of Essential Medicines and Personal Protective Equipment

The proposed rule also seeks comment on a potential separate payment under the Inpatient Prospective Payment System for domestic procurement of personal protective equipment and essential medicines. Although this request is not an OPPS payment proposal, it is relevant to the broader patient-centered goal of ensuring that health care providers can reliably obtain the products they need to deliver care. Recent supply

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[95] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 5–7.

[96] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41990–95.

[97] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41990–95.

[98] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41990–95.

disruptions have demonstrated that shortages can quickly lead to treatment delays, substitutions, canceled procedures, and added burden for patients and caregivers.[99,100]

The NHC supports exploring payment approaches that strengthen supply resilience when they are evidence based, targeted to genuine vulnerabilities, and designed so that additional spending produces measurable improvements in availability. CMS should define what products qualify as essential, identify the specific supply-chain risk the payment is intended to address, and establish accountability for whether the additional payment changes procurement behavior. A broad domestic preference without clear linkage to resilience could increase costs without improving patient access.[101,102]

Any future policy should also avoid creating new affordability pressures for beneficiaries or payment incentives that steer providers away from certain clinically appropriate products. Patient and provider organizations should be engaged in identifying medicine categories where shortages or concentrated supply pose the greatest risks to patient care. Measures of success should include reduced shortage duration, fewer care disruptions, and improved ability of providers to maintain needed inventory, rather than domestic procurement volume alone.[103]

Rural, Safety-Net, and Other Essential Access Providers

Several proposals in the CY 2027 rule have different implications depending on the availability of alternative care in a community. The NHC therefore encourages CMS to assess rural and safety-net effects across the rule rather than only within the provisions that explicitly reference rural hospitals. A payment reduction that can be absorbed in a market with several competing imaging centers, infusion providers, or ASCs may have a very different effect in a community where a single hospital outpatient department can provide a service. Similarly, an administrative requirement that is manageable for a large health system may impose disproportionate burden on a smaller facility with limited compliance and information-technology staff.[104,105]

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[99] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41995–42000.

[100] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Policy Considerations to Prevent Drug Shortages and Mitigate Supply Chain Vulnerabilities in the United States* (April 2, 2024), https://aspe.hhs.gov/reports/preventing-shortages-supply-chain-vulnerabilities.

[101] HHS ASPE, *Policy Considerations to Prevent Drug Shortages*.

[102] FDA, *Drug Shortages: Root Causes and Potential Solutions*, October 2019, updated February 2020, https://www.fda.gov/drugs/drug-shortages/report-drug-shortages-root-causes-and-potential-solutions.

[103] HHS ASPE, *Policy Considerations to Prevent Drug Shortages*.

[104] Bai et al., “Varying Trends in the Financial Viability,” 942–48.

[105] American Cancer Society, “Change the Odds: Cancer’s Impact on Rural America,” February 8, 2025, https://www.cancer.org/cancer/latest-news/our-impact/change-the-odds-cancers-impact-on-rural-america.html.

The proposed rural Sole Community Hospital exemption from the off-campus imaging policy appropriately recognizes one dimension of this problem, but CMS should apply the same analytical discipline to other major provisions. The agency should evaluate whether the 340B acquisition-cost adjustment and remedy offset, changes in device-intensive ASC payment, IPO and ASC CPL expansion, OQR validation changes, and new provider-based attestation requirements have disproportionate effects on providers that serve geographically isolated populations or a high share of beneficiaries with complex needs. The purpose of such analysis is not to preserve every existing payment differential; it is to identify circumstances in which a policy that appears neutral on average may reduce practical access because no substitute capacity exists.[106,107]

The NHC recommends that CMS use a consistent set of rural and safety-net access indicators across payment systems. These could include median and upper-quartile travel distance to alternative sites of care, specialty-specific wait times, service-line closures, reliance on interfacility transfer, the number of competing providers within a reasonable travel radius, and the share of beneficiaries who are dually eligible or otherwise face significant access barriers. Where claims data cannot capture caregiver availability, transportation reliability, or other nonmedical constraints, CMS should supplement quantitative analysis with targeted engagement of patients, caregivers, and community organizations.[108]

CMS should also distinguish between protecting access and protecting inefficiency. Rural or safety-net status should not automatically exempt a provider from every effort to improve value or reduce unnecessary utilization. Instead, exceptions and transitional protections should be narrowly tied to evidence that the provider performs an essential access function or that a payment change would create a meaningful risk of service loss before alternative capacity can develop. This approach is consistent with the NHC's broader preference for targeted safeguards over permanent categorical exclusions and would allow CMS to pursue payment integrity while maintaining accountability for patient access.[109]

Technical assistance can also help protect patient access. Smaller hospitals and ASCs may have greater difficulty implementing new reporting formats, eCQM validation procedures, separate NPI requirements, SaMS coding changes, or prior authorization workflows. CMS should provide practical implementation resources, model workflows, help-desk support, and sufficient lead time, especially where failure to comply can reduce payment. Administrative simplification can itself be a patient-protection strategy when it allows limited staff capacity to remain focused on care delivery rather than avoidable rework.[110]

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[106] CMS, "CY 2027 OPPS/ASC Proposed Rule," 41927–29, 42011–18.

[107] Bai et al., "Varying Trends in the Financial Viability," 942–48.

[108] American Cancer Society, "Change the Odds."

[109] National Health Council, "CY 2026 OPPS & ASC Proposed Rule," 10–12.

[110] Kyle and Frakt, "Patient Administrative Burden," 755–65.

Patient Access Monitoring, Data Transparency, and Mid-Course Correction

Many of the policy changes proposed in this rule may have consequences that cannot be fully anticipated before implementation. Claims, enrollment, acquisition-cost, quality, and other administrative data can identify changes in where services are furnished and how utilization shifts, but they cannot fully predict whether a beneficiary will experience a longer wait, lose access to a local service, struggle to arrange transportation to a new site of care, or abandon treatment because a new administrative step is too difficult to navigate. The NHC therefore recommends that CMS formalize a patient-access monitoring framework for major OPPS and ASC reforms that combines available quantitative data with targeted patient and caregiver feedback so that emerging access problems are identified systematically rather than anecdotally.[111]

The framework should begin with policy-specific hypotheses. For example, if a site-of-service payment change is expected to move imaging toward lower-cost settings without reducing access, CMS should track whether freestanding capacity actually absorbs that volume, whether wait times remain stable, whether beneficiary travel increases, and whether clinically complex patients remain able to receive imaging in a hospital setting when necessary. If prior authorization is expected to reduce unnecessary botulinum toxin utilization without disrupting appropriate care, CMS should track not only aggregate utilization but also decision times, repeat submissions, treatment delays, denial reversals, and the share of established patients whose scheduled therapy is interrupted. If a 340B payment change is expected to improve payment accuracy without affecting service availability, CMS should monitor infusion capacity, specialty drug administration, and relevant outpatient service closures among affected hospitals.[112,113]

CMS should make as much of this information public as privacy and statistical reliability permit. Public reporting does not need to expose proprietary data or create a new reporting burden for every facility. The agency can use claims, enrollment, existing quality data, targeted surveys, and information already collected through program operations to publish national and regional indicators. For policies with significant payment redistribution or risks to access, CMS could issue an implementation report after six or twelve months and again after the first full year. Patient organizations would then have a common empirical foundation for identifying whether observed problems are isolated, geographic, or systemic.[114]

The monitoring framework should also include a structured pathway through which patients, caregivers, and patient organizations can report recurring access concerns during implementation rather than waiting for the next annual rulemaking cycle. This

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[111] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–4.

[112] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41887–95, 41898–41904, 41975–78.

[113] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–4, 14–15.

[114] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–4.

would be particularly valuable for rare diseases and other populations where national claims volume may be too small to reveal an emerging problem quickly. Qualitative reports should be used to identify questions for further analysis rather than treated as a substitute for quantitative evidence, and CMS should publish enough information about issues received and agency responses to allow stakeholders to understand whether concerns are isolated, geographic, or systemic.[115]

Monitoring should ultimately be connected to action. CMS should identify in advance the types of findings that would warrant additional review and the tools available to address problems. These could include technical guidance, additional transition time, changes to coding or payment instructions, contractor education, targeted exceptions, or future rulemaking. CMS should be prepared to make course corrections when real-world evidence contradicts assumptions underlying a policy, particularly in an outpatient payment system that spans a wide range of providers, services, and patient populations.[116]

Administrative Burden, Alignment Across Programs, and Implementation Sequencing

The CY 2027 OPPS and ASC rule includes multiple changes that may require hospitals, ASCs, safety-net providers, and other organizations to modify billing systems, EHR, reporting processes, contracts, clinical workflows, staff training, and patient communications on overlapping timelines. Even where each requirement has a reasonable policy rationale, cumulative implementation burden can divert resources from patient care and increase the likelihood of technical errors that result in payment disruption or delayed scheduling. The NHC therefore encourages CMS to evaluate implementation timelines across the rule as a whole rather than treating each provision as an independent administrative project.[117]

CMS should sequence major changes according to operational complexity and patient risk. Policies that address immediate patient harm or correct a clearly demonstrated payment problem may warrant rapid implementation, while complex data, reporting, coding, or valuation changes may benefit from phased adoption, testing, or additional technical assistance. January 1 need not be the effective date for every new administrative process solely because it is the beginning of the payment year. Staggered implementation can improve data quality, reduce inadvertent noncompliance, and make it easier for CMS to attribute observed effects to a particular policy rather than to several changes implemented simultaneously.[118]

Alignment across Medicare programs can also reduce burden. Where hospital price transparency, OQR, provider-based enrollment, prior authorization, interoperability, or

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[115] National Health Council, *Rubric to Capture the Patient Voice.*

[116] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–4.

[117] Kyle and Frakt, “Patient Administrative Burden,” 755–65.

[118] Kyle and Frakt, “Patient Administrative Burden,” 755–65.

other CMS requirements rely on overlapping information, the agency should use common definitions and permit reuse of data whenever possible. Digital transformation is most valuable when it eliminates duplicative documentation and manual work rather than reproducing existing administrative requirements electronically. CMS should also coordinate subregulatory guidance across program components so that providers and organizations do not receive inconsistent instructions from separate CMS offices or contractors concerning closely related requirements.[119]

Patient-facing communications should be aligned as well. A beneficiary may encounter multiple policies at once without knowing which payment system or regulatory requirement is responsible for a delay, estimate, or site-of-care recommendation. CMS should provide plain-language materials that explain key changes and clarify that coverage eligibility, site-of-service payment, prior authorization, and quality reporting are distinct concepts. When a policy directly affects patient choice or expected financial responsibility, information should be available before the point at which the patient must make a decision.[120,121]

Finally, the NHC recommends that CMS apply a proportionality principle to enforcement during transitions. Intentional noncompliance or conduct that creates patient harm warrants a strong response, but a technical error during implementation should generally be addressed through education and an opportunity to correct before it results in a severe payment consequence, where statute permits. Allowing organizations to correct technical errors during implementation does not weaken accountability. Rather, it can help new requirements achieve their intended purpose without creating avoidable disruption.[122]

Conclusion

The CY 2027 OPPS and ASC proposed rule presents important opportunities to improve payment accuracy, expand the settings in which beneficiaries may receive clinically appropriate care, streamline quality reporting, strengthen the usefulness of public information, and modernize payment for emerging technologies. At the same time, it includes significant payment, site-of-service, utilization-management, and administrative changes that could redistribute resources across hospitals and service lines and, if not implemented carefully, affect whether patients can continue to obtain care in the settings and communities where they need it. The NHC encourages CMS to evaluate the final policies as an integrated package and to keep patient access,

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[119] National Health Council, “NHC’s Comments on the CMS Proposed Rule on Interoperability and Prior Authorization,” June 15, 2026, 3, 17–18, https://nationalhealthcouncil.org/letters-comments/nhcs-comments-on-the-cms-proposed-rule-on-interoperability-and-prior-authorization/.

[120] National Health Council, “NHC’s Comments on the CMS Proposed Rule on Interoperability and Prior Authorization,” 3, 8–9.

[121] Bechel et al., “Usability of Hospital Price Estimators,” 1253–59.

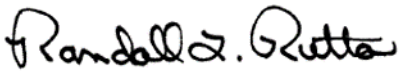
[122] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–4.

affordability, clinical appropriateness, continuity of care, and meaningful patient choice at the center of implementation.[123]

In particular, the NHC recommends that CMS pair major payment and site-of-service reforms with disaggregated impact analyses, transparent methodology, reasonable transitions, and clear access monitoring; preserve individualized clinician-patient decision-making as the IPO list and ASC CPL expand; and narrow prior authorization to circumstances in which evidence demonstrates a meaningful program-integrity benefit. CMS should also continue to protect access to high-cost diagnostics, innovative technologies, and non-opioid pain management; design SaMS payment around clinical value, patient outcomes, clinician accountability, transparency, and accessibility; strengthen price transparency around information patients can use to understand and compare their care options; and use patient and caregiver engagement to shape quality measures, advance care planning, and other emerging policies.[124,125]

Thank you for the opportunity to provide feedback on the CY 2027 OPPS and ASC proposed rule. The NHC stands ready to work with CMS and other stakeholders to ensure that the final policies support a Medicare outpatient system that is affordable and sustainable while remaining responsive to the needs of people living with chronic diseases and disabilities and their caregivers. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer

[123] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41737–38, 42011–18.

[124] CMS, “CY 2027 OPPS/ASC Proposed Rule,” 41737–38, 42011–18.

[125] National Health Council, “CY 2026 OPPS & ASC Proposed Rule,” 2–8, 12–15.