Texas Hospital Association

1108 Lavaca Street, Suite 700
Austin, Texas 78701
512/465-1000
www.tha.org

September 15, 2025

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

Re: CMS–1834–P, Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency; Proposed Rule (Vol. 90, No. 133), July 17, 2025.

Dear Doctor Oz:

On behalf of our more-than 460 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association (THA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed changes to the Outpatient Prospective Payment System (OPPS) and other items included in the proposed rule. While THA supports efforts to curb growing health care costs, especially in taxpayer-funded programs, we are concerned that multiple elements of the proposed rule will financially destabilize the hospital industry and negatively impact our patients and their communities.

Updates Affecting OPPS Payments – Proposed Conversion Factor Update

As noted in prior submissions to CMS by THA and the American Hospital Association (AHA), proposed market basket updates have historically understated the true increase in costs and have been inadequate to maintain reimbursement levels. After years of compounding market basket updates that track behind real medical inflation, THA is disappointed to see a proposed update to the market basket of just 3.2% and once more urges CMS to review its forecasting methodology. Additionally, THA is surprised by the size of the proposed -0.8 percentage-point productivity adjustment as mandated by the Affordable Care Act (ACA). Not only is this adjustment notably higher than last year's finalized adjustment of -0.5 percentage points, but it is also larger than any in the past four years and seems to overstate actual gains in productivity. Notably, this disappointing payment increase comes after a more-than 5% increase in payments to Medicare Advantage (MA) plans. Once more, THA urges CMS to reconsider its methodologies for payment updates that reflect the actual cost of the high-quality and high-value care THA members deliver in their communities.

Prospective Adjustment to Payments for Non-Drug Items and Services to Offset the Increased Payments for Non-Drug Items and Services Made in Calendar Years (CY) 2018 Through 2022 as a Result of the 340B Payment Policy

THA strongly opposes CMS's proposal to accelerate the clawback of funds under 42 § 419.32(b)(1)(iv)(B)(*12*). THA and AHA have explained many times why any clawback should not have been contemplated. THA endorses AHA's legal analysis and urges the agency to reconsider its position. CMS should rescind subsection 419.32(b)(1)(iv)(B)(*12*) altogether.

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If CMS persists with this proposed clawback, it should certainly *not* accelerate the existing timeline. When it codified a 16-year timeline in the Final Remedy Rule, CMS stated that it sought to "comply with the statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to impacted entities." In suddenly changing course, CMS now asserts that it "insufficiently accounted for" what it calls the "main premise of the Final Remedy rule": the need to return 340B hospitals to the financial position they would have been in if CMS never implemented its illegal policy in the first place. According to the proposed rule, a six-year time frame "better balances that goal and [its] budget neutrality obligations against hospital burden and reliance interests."

This analysis gets the balancing completely wrong because it downplays the burden and reliance interests of hospitals subject to higher clawback rates. First, the proposed rule states: "Because we are proposing this policy in advance of CY 2026 and before any rate reductions go into effect for OPPS and Medicare Fee for Service payments, any reliance interests hospitals have in a policy that has not been implemented yet for these payment systems would be minimal." This reasoning reflects a fundamental misunderstanding of how hospitals operate in the real world. All hospitals and health systems make planning decisions about budgets based on what they expect to occur in future years and therefore began planning for this clawback as soon as CMS announced it in 2023. As part of those medium- and long-term planning decisions, our members took CMS at its word and factored in a 0.5% clawback. It therefore makes no difference that those rate reductions have not yet gone into effect. If the agency finalizes this unexpected increase from 0.5% to 2% just two months before 2026, hospital budgets based on that 0.5% figure will be upset with little time to readjust, creating serious cash flow problems. That is the paradigmatic reliance interest, and the agency is wrong to state that those interests are "minimal."

Second, CMS also must better account for the burden that the proposed accelerated timeline will inflict on THA members. An annual increase from 0.5% to 2% will meaningfully impact hospital operating margins. Relatedly, the agency's balancing fails to account for adverse financial trends since 2023. As a general matter, hospital costs have increased, and government reimbursement continues not to keep pace. Shifts in care patterns will present our members with older, sicker populations with more complex, chronic conditions that are more costly to care for. In addition, nowhere does the proposed rule consider the recent passage of the One Big Beautiful Bill Act (OBBBA), which will have direct, adverse impacts on our hospitals' finances. The average hospital is expected to lose between 0.4% and 1.4% of its annual net revenue due to OBBBA's health care provisions, translating to $25 billion per year in lost hospital revenue nationwide.[1] If CMS aims to balance its purported "budget neutrality obligations against hospital burden and reliance interests," it cannot ignore the effects of the OBBBA or these other financial trends.

All in all, the proposed rule errs by conducting a new balancing that completely fails to account for the burdens that it will impose on hospitals. Although the proposal does not sufficiently explain how CMS conducted its balance, it appears as if the agency simply kept the burdens constant from the Final Remedy Rule and readjusted the value of the perceived need to achieve budget neutrality.

[1] Kodiak Solutions. (Sept. 2025). How four different Medicaid disenrollment scenarios would impact hospitals' net revenue and income.

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The final rule must discuss and account for these changes on the reliance interest/burden side of the balance. And when it does, the balancing will tip sharply *against* accelerating the timeline.

Finally, the proposed rule fails to consider a sufficient number of alternatives. It states that the agency considered an even faster clawback period (three years). But the agency nowhere explains why it arbitrarily chose that alternative when others exist. The agency easily could have considered timelines between six and 16 years. It could have – and should have – considered periods longer than the existing 16-year timeframe to better account for post-OBBBA realities. The agency must consider these reasonable alternatives and explain why, in its view, six years achieves the balance needed better than these other time frames.

Ultimately, THA urges CMS to abandon this unlawful, unwise proposal. Because *any* clawback is illegal, it should rescind subsection 419.32(b)(1)(iv)(B)(*12*) altogether. If CMS continues to disagree with that legal analysis, it should maintain or extend the existing clawback timeline.

OPPS Payment for Drugs, Biologicals and Radiopharmaceuticals - Notice of Intent to Conduct Medicare OPPS Drugs Acquisition Cost Survey

Considering the headwinds faced by hospitals through inadequate Medicare payment updates, inappropriate payer behavior in the Medicare Advantage program and the expected reduction in health care coverage resulting from OBBBA (which will be exacerbated if the Enhanced Premium Tax Credits expire), THA is disappointed that CMS has proposed to conduct a drug cost acquisition study. The administrative and regulatory burden on hospitals has never been higher, and our members must increasingly dedicate staff time to ensuring patients receive the care to which they are entitled under their health plan. The proposed survey is just another in a succession of unfunded mandates imposed on hospitals, though in this case the goal appears to be an additional reduction in already insufficient payments from CMS to hospitals for the necessary care they provide.

As AHA and the Government Accountability Office have made clear to CMS, surveys are extraordinarily costly and create non-monetary burden on hospital staff. The proposed rule estimates that each hospital will require 73.5 hours to complete the survey at an approximate cost of $4,000. However, input from our member hospitals raises serious doubt about the accuracy of that estimate, and THA understands that the time burden and cost would be a multiple of those estimated.

The immediate effects aside, THA presumes that the ultimate purpose of this survey is to reduce future Medicare reimbursements for drugs, effectively shifting the benefits of the 340B program from covered entities to CMS. THA maintains that such an effort is misguided and will create negative impacts for Texas communities. Hospitals that currently qualify for the 340B program serve disproportionately high numbers of Medicare and Medicaid patients and provide valuable safety nets for our state's immense rural population, as well as the most vulnerable Texans. Hospital covered entities serve these patients despite incurring a loss of roughly 17 cents on every dollar spent on care – in other words, hospitals pay to provide necessary services to the neediest in their communities. The Medicare shortfall is challenging enough but, as AHA has communicated to

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CMS, Medicare payment updates during the Biden administration failed to keep up with the runaway inflation at the time. The Medicare Payment Advisory Committee reported that hospital Medicare margins reached an all-time low last year and were not expected to rebound in 2025.

Finally, THA is concerned with the likelihood that its survey will cost hospitals significant sums without producing useful results, as indicated by CMS' proposed survey questions. For example, CMS asks whether it "should make responding to the survey a mandatory requirement of all hospitals paid under OPPS," but CMS identifies no statutory authority for such a mandatory requirement. Section 1833(t)(14)(D)(iii), the only statute cited in that discussion, does not provide the agency with the authority to mandate hospital responses, and given the hefty burden of responding, CMS runs the risk of a low response rate. Without such statutory authority, the agency must explicitly acknowledge in the final rule and subsequent data collection efforts that responding to any cost acquisition survey is purely *voluntary*. Thus, the response to CMS' statement that it "welcome[s] comment on how we might propose to interpret non-responses to the survey" is clear – it shouldn't. *None of the options* provided by CMS in the proposed rule would satisfy the statutory requirement that a survey "… have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug." CMS simply will not have the information necessary to determine statistical significance. Echoing AHA's comments: If the agency is truly concerned about the lack of responses from hospitals, it should not issue a survey in the first place.

Services That Will Be Paid Only as Inpatient Services

In receiving feedback from our members, THA is similarly concerned with CMS' proposal to eliminate the Inpatient Only (IPO) list over the next three years. The IPO list was created to ensure that Medicare beneficiaries – leaders in our communities and beloved family members – receive the highest-quality care resulting in the best possible outcomes. CMS' proposal considers only the cost of the setting in which care is provided and risks undermining clinical appropriateness in care delivery. Indeed, many of the IPO list's services are complicated, including invasive surgeries that may involve multiple days in the hospital, special protections against infections, and significant rehabilitation and recovery periods, requiring the care and coordinated services of the inpatient setting of a hospital. Unfortunately, patients may not understand these risks and could pressure their clinicians to provide care in a less optimal setting. Equally as concerning, the removal of the IPO list may jeopardize the well-being of MA beneficiaries, as well, leading to payers denying necessary inpatient admissions based solely on cost.

The more appropriate action by CMS is to follow its existing policies to examine each service on the IPO list – considering, for example, average length of stay, peer-reviewed evidence and patient comorbidities. Such an approach, grounded in data, would inform precisely which services should remain on the IPO list and ensure that all beneficiaries receive the highest possible level of care.

Nonrecurring Policy Changes – Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

THA opposes CMS' proposal to reduce the payment for drug administration services furnished in excepted off-campus hospital outpatient departments (HOPD) to the "PFS-equivalent" rate of 40%

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of the OPPS rate. We also oppose the option the agency raises of possibly expanding such site-neutral cuts to other services furnished in HOPDs. We urge the agency to withdraw these proposals from consideration.

CMS' proposal inappropriately equates care provided in hospital outpatient clinics with the less complex care delivered at independent physician offices and other freestanding sites. This is a flawed assumption, as the two settings are fundamentally different in both the complexity and intensity of services provided. Current OPPS payment rates are structured to reflect these significant differences and the greater resource requirements in hospital settings. Hospitals are subject to a rigorous set of regulatory and safety requirements that do not apply to independent physician offices. For example, hospitals must ensure that a licensed pharmacist directly supervises the preparation of medications, whereas physician offices may not be held to this standard. Hospital clinics are also required to maintain specialized environmental controls –such as positive air pressure rooms and advanced cleaning protocols – to minimize the risk of microbial contamination and safeguard both patients and staff from exposure to hazardous drugs. These safeguards are essential for patient safety, particularly for complex or high-risk therapies commonly administered in hospitals.

Furthermore, hospitals provide comprehensive care coordination and must comply with extensive federal and state safety standards, including those mandated by the Food and Drug Administration, The Joint Commission and other accrediting bodies. These requirements impose considerable operational costs and necessitate specialized staff and infrastructure that are not required in less regulated, freestanding facilities. To disregard these material differences by applying equivalent payment rates risks undermining the safety and quality of care delivered in hospital outpatient clinics and may inadvertently incentivize the provision of complex care in inadequately equipped settings.

CMS also fails to consider other explanations for the increase in drug administration. Indeed, CMS provides scant evidence that higher payments for these services are incentivizing hospital acquisition of independent physician offices and leading to an "unnecessary increase in the volume of services." This assertion ignores many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from both Medicare and private payers, as well as excessive administrative burdens[2,3] CMS also fails to account for the fact that HOPDs serve a sicker, more clinically complex and more economically vulnerable Medicare population.[4,5]

Finally, THA incorporates by reference the comments by AHA regarding CMS' statutory authority to reduce payments to excepted HOPDs to the level of nonexcepted HOPDs, particularly in a

[2] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf
[3] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care
[4] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025
[5] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

nonbudget-neutral manner. As AHA details, the rule states that "section 1833(t)(2)(F) of the [Social Security] Act provides authority to implement this policy," and that the D.C. Circuit's decision in *American Hospital Association v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020), supports AHA's interpretation. As AHA details, legal developments since that court decision cast significant doubt on its continued viability and, more importantly, undermine the agency's reliance on Section 1833(t)(2)(F).

Nonrecurring Policy Changes – Request for Information: Adjusting Payment Under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings

As noted in the previous section, CMS has failed to make any effort to ascertain the cause of changes in the volume of services by setting. Rather, the agency presumes an economic motive, when consideration of patient risks and provider quality goals are substantial factors in a clinician's decision regarding site of service. Given this oversight, THA opposes this effort and any payment change that financially incents riskier care.

Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges, Proposed Market-Based Medicare Severity-Diagnosis Related Groups (MS-DRG) Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights Under the Inpatient Prospective Payment System

CMS proposes collecting market-based payment rate data on the Medicare cost report for cost reporting periods ending on or after Jan. 1, 2026. Hospitals would use the payer-specific negotiated charges from their most recent machine-readable file published prior to the submission of their cost report to report the median payer-specific negotiated charge that they negotiated with their MA organizations. The agency proposes to then use the submitted information to set inpatient prospective payment system (IPPS) relative weights beginning in fiscal year 2029.

As noted by AHA, this proposal contains serious policy and legal deficiencies. Because of this, we strongly urge its withdrawal. Specifically, this proposal would impose a significant new regulatory burden with no stated rational basis and ignores critical issues associated with the use of MA negotiated rates to set Medicare fee-for-service MS-DRG relative weights. Finally, CMS has not and cannot analyze the impacts of its proposed policy because the underlying data are not currently maintained in the format CMS would require. Blindly using MA data to overhaul the IPPS relative weights will result in substantial negative impacts for our hospitals and the communities we serve. Finally, the proposal is likely not authorized by the cited statutory authority and is precluded by other existing statutory requirements.

Proposal to Revise the Requirements for Hospitals to Make Public Their Standard Charges and CMS' Enforcement of Hospital Price Transparency Regulations

THA and the Texas hospital industry are committed to advancing price transparency and share the administration's goal of giving patients clearer, more actionable cost information. However, our members must now adhere to both federal and state regulations that constantly move the goalposts and create an unsustainable administrative burden on the hospital industry while doing little to further patient understanding of their health care expenses. Earlier this year, THA provided CMS recommendations on improving efforts at price transparency – see our previous response to the CMS Hospital Price Transparency Accuracy and Completeness Request for Information – and

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we echo those points here. However, we incorporate by reference the arguments put forth by AHA in its comments on the current rule relating to concerns with price transparency attestation and allowed-amount data elements.

Like the Trump administration, THA wishes to Make America Healthy Again and believes that this can be achieved through improved education on nutrition, identifying and supporting necessary patient behavior changes and continuing to adapt health care services to reflect the needs of local communities. We believe that hospitals, with their wide range of trained health care professionals and support staff, will play an instrumental role in this effort, especially in rural and underserved areas where hospitals may be the most accessible source of care. Unfortunately, CMS' proposed OPPS payment rule contains numerous provisions that would destabilize hospitals and undermine the Department of Health and Human Services' signature health initiative. THA and its members strongly urge CMS to reconsider the elements on which we have commented above.

If THA can provide additional information or answer any questions, please contact Matt Turner at mturner@tha.org.

Sincerely,

Matt Turner, PhD, MPH
Senior Director, Heath Care Policy
Texas Hospital Association