**September 15, 2025**

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

# Re: Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule

CMS-1834-P

Dear Dr. Oz:

Thank you for the opportunity to respond to the proposed CY 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems rule. Arnold Ventures fully supports the Administration's commitment to expanding site-neutral payment reform and strengthening hospital price transparency to lower health care costs, improve patient choice, and enhance health care market competition. We look forward to the Administration's continued efforts on these issues.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. As a philanthropy, we do not accept funding from industry or have a financial stake in policy outcomes. Our work within the health care sector is driven by a recognition that the current system costs too much, leading to access issues for patients and affordability challenges for families and businesses. One of our priorities is reducing the high prices charged by hospitals and other providers in the commercial market to lower health care costs for families, employers, and taxpayers. Given that health care consolidation is a primary driver of high and rising provider prices, much of our work is aimed at improving market competition and preventing further consolidation. Additionally, we are focused on policies that improve transparency and directly limit prices or price growth where appropriate.

As you will see below, we strongly urge the Administration to finalize their proposals on site-neutral payments and price transparency. We also outline recommendations for expanding site-neutral payments beyond those proposed in this rule in order to lower costs for Medicare beneficiaries and the Medicare program, and reduce incentives for hospitals to vertically consolidate with providers. We add recommendations on hospital price transparency changes to ensure that consumers, employers, researchers, and policymakers have the necessary data to pursue lower-cost care and inform policy development aimed at improving health care affordability. We thank the agency for its work in this area, given your many competing priorities, and appreciate the opportunity to provide input.

## Proposed Changes to Expand Site-Neutral Payment Reform

Patients and taxpayers are charged billions more simply because of where they receive care. Medicare currently pays two to four times more for a given service provided in a hospital outpatient department than they do when that same service is delivered in a physician's office. This has encouraged hospitals to buy up physician practices and rebrand them as hospital outpatient departments to bill for the same services at the higher hospital rate – even when the doctor and services remain the same.

This also raises costs and prices for those with commercial insurance and increases taxpayer subsidies for commercial insurance. Costs go up directly because commercial insurers tend to follow Medicare's lead on payment policies and those policies lead services to move to the more expensive sites of care. Furthermore, as hospital systems grow larger, they are then able to exert their market power to demand higher prices in insurer negotiations for all of their services, given there is less competition. Furthermore, there is substantial evidence that quality does not improve despite the increase in patients' premiums and cost sharing.[1]

Medicare's adoption of site-neutral payment policy will reduce payment differentials for routine and safe services to ensure patients and taxpayers pay the same amount for the same services regardless of where the service is performed. **Arnold Ventures supports legislative action to enact comprehensive site-neutral reform in both Medicare and the commercial market.[2] Such legislation would:**

- Lower Medicare spending and save around $150 billion for taxpayers over 10 years.[3]
- Reduce Medicare beneficiaries' premiums and cost sharing by $80 billion over 10 years.[4]
- Save employers and consumers in the commercial market between $140 billion and $470 billion.[5]

**CMS Proposal on Drug Administration Site Neutrality**

**Arnold Ventures strongly supports the Administration's proposal to pay for drug administration services on a site-neutral basis when performed at off-campus hospital outpatient departments.** The Congressional Budget Office projects that moving to site-neutrality for drug administration, as the rule proposes, would save Medicare $5.6 billion over 10 years.[6] This would reduce beneficiary premiums and cost-sharing by around $3.5 billion.[7]

Paying at a rate consistent with the level at independent physicians' offices makes sense given the fact that drug administration is performed frequently and safely at independent physician offices and these services represent a sizable share of Part B spending. This is also a reasonable use of CMS's authority to control the increased volume of these services at higher cost sites-of-care. It follows the methodology used in 2019 for Evaluation and Management

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[1] KFF. 2024. *Ten Things to Know About Consolidation in Health Care Provider Markets.* https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[2] Arnold Ventures. 2025. *New Research Brief Finds Billions in Savings for Seniors.* https://www.arnoldventures.org/stories/new-research-brief-finds-billions-in-savings-for-seniors

[3] Ibid.

[4] Ibid.

[5] Committee for a Responsible Federal Budget. 2021. *Equalizing Medicare Payments Regardless of Site-of-Care.* https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

[6] CBO. 2024. Options for Reducing the Deficit: 2025 to 2034. https://www.cbo.gov/budget-options/60908

[7] Arnold Ventures calculations based on: Bulat, Tim and Ryan Brake. Actuarial Research Corporation. 2025. *Updated Estimates of Site Neutrality and Evaluation of the Cassidy-Hassan Framework.* https://www.arnoldventures.org/resources/updated-estimates-of-site-neutrality-and-evaluation-of-the-cassidy-hassan-framework

services (E&M) for off-campus outpatient departments previously "excepted" from the Bipartisan Budget Act (BBA) of 2015's site-neutral payment rates, which only applied to locations built after the legislation's passage.

Drug administration payment rates at excepted sites-of-service are more than double the rates at non-excepted locations, and those non-expected locations account for less than 2% of service volume – which is why CMS's proposal is well-targeted to reduce volume growth at the higher cost locations and will save taxpayers and beneficiaries money. As CMS reports in their proposed rule, there has been an increase in the volume of drug administration services at these hospital-owned sites over time, growing by 35 percent between 2011 to 2019.[8] Total volume growth comparisons are difficult after 2019 due to the Covid pandemic, but CMS reports that growth has continued on a per-beneficiary basis since 2022.[9]

This policy will be particularly impactful for services used by patients with high utilization, like those undergoing chemotherapy who represent a small portion of the population, but are disproportionately harmed by the current state of drug administration payment. According to MedPAC, 51 percent of chemotherapy administration services were provided in HOPDs in 2019, up from 35 percent in 2012.[10]

The highest utilizing 5,000 patients who received chemotherapy in 2022 at excepted off-campus HOPDs paid $1,055 more in cost sharing than they would have had payments been site neutral.[11] A meaningful number of similar high utilizing beneficiaries with other conditions are paying hundreds (and occasionally thousands) of dollars more per year in cost sharing than had they received treatments at physician offices or non-excepted off-campus outpatient departments.

**CMS Exploration of Moving to Site Neutrality for Additional Services**

**Arnold Ventures strongly supports the Administration's exploration of other services to pay on a site-neutral basis, which would create substantial savings for taxpayers and beneficiaries**. Targeting imaging services specifically is promising as CMS looks to other services where volume has increasingly moved from less costly independent offices to higher-priced, hospital-owned off-campus outpatient departments.

Imaging services are widely utilized by Medicare beneficiaries – over 1.6 million beneficiaries received such services in 2022 alone.[12] As with drug administration services, imaging services are routine and safe regardless of setting. Applying that site-neutral rate for imaging services at all off-campus outpatient departments would save Medicare $7.6B over 10 years and reduce Medicare beneficiaries' out-of-pocket costs and premiums by around $4.8 billion.[13]

The Administration also requested comment on moving to site neutrality for E&M services at on-campus outpatient departments, following their already implemented policy making E&M services site-neutral at all off-campus

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[8] Centers for Medicare & Medicaid Services. 2025. *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems*. Federal Register 90(135). https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical#h-251

[9] Ibid.

[10] Medicare Payment Advisory Commission. 2022. *Report to Congress. Chapter 6: Aligning fee-for-service payment rates across ambulatory settings.* https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

[11] Bulat, Tim and Ryan Brake. Actuarial Research Corporation. 2024. *Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals*. https://craftmediabucket.s3.amazonaws.com/uploads/Sizing-Medicare-Off-Campus-HOPD-Site-Neutrality-Proposals-2024.01.03.pdf

[12] Ibid.

[13] CBO. 2024. Options for Reducing the Deficit: 2025 to 2034. https://www.cbo.gov/budget-options/60908; Arnold Ventures calculations based on: Bulat, Tim and Ryan Brake. Actuarial Research Corporation. 2025. *Updated Estimates of Site Neutrality and Evaluation of the Cassidy-Hassan Framework*. https://www.arnoldventures.org/resources/updated-estimates-of-site-neutrality-and-evaluation-of-the-cassidy-hassan-framework

locations. **Arnold Ventures supports paying for all E&M visits, whether at on- or off-campus outpatient departments, at the lower independent physician rate.** We estimate this would save taxpayers around $22 billion and reduce beneficiary premiums and cost sharing by around $13 billion over 10 years.[14]

E&M services related to cancer care have specifically seen large volume increases to on-campus outpatient departments in recent years, so this shift would be particularly beneficial to these patients with high utilization: reducing out-of-pocket costs and potentially increasing market transparency, community-based care, and patient choice.

**Other Services and Other Possible CMS Action**

CMS requested suggestions for what other services they might consider for an expansion of site-neutral payments. The MedPAC list of 66 clinical services is a good place to start.[15] It includes 57 Ambulatory Payment Classifications (APCs) where services are safely performed a majority of the time in freestanding physicians' offices – making those natural choices in which to align payments at the lower rates paid to those offices. Furthermore, these APCs make up most of the services performed at off-campus outpatient departments, and **expanding site neutrality for all services performed at off-campus, hospital-owned locations would save Medicare around $24 billion over 10 years and beneficiaries $15 billion in reduced premiums and cost sharing.[16]**

There are other incremental steps CMS can take to expand site neutrality, including by:

- Narrowing the definition of free-standing emergency departments to those that function truly as an emergency department, such as those that provide most services on an unscheduled basis.
- Updating CMS claims forms by adding additional modifiers to the "Place of Service" codes to better understand additional information about the provider when a facility fee or higher payment rate is being billed on provider claims. Modifiers could include "owned by" or "affiliated with" to indicate when a provider is potentially charging an additional site related fee, even if in an office-based setting. Adding these modifiers will be a foundational step in helping researchers and policymakers understand these billing practices and how frequently facility-related fees are being assessed, the magnitude of these fees, the prices being billed for the services, and which types of providers might be charging such fees and high prices. Because many plans use these forms for their commercial claims as well, this information can also help inform facility fee analysis and spending in the commercial market.

## Proposed Changes to Hospital Price Transparency Requirements

The primary driver of high health care costs for the privately insured is the excessive prices for health care services charged by powerful hospitals and providers. These prices – on average, 2.5 times more than what Medicare pays for the same service – are often set arbitrarily and are irrationally high.[17] These high prices flow through the system as a

[14] Arnold Ventures calculations based on: Bulat, Tim and Ryan Brake. Actuarial Research Corporation. 2025. *Updated Estimates of Site Neutrality and Evaluation of the Cassidy-Hassan Framework.* https://www.arnoldventures.org/resources/updated-estimates-of-site-neutrality-and-evaluation-of-the-cassidy-hassan-framework

[15] Medicare Payment Advisory Commission. 2022. *Report to Congress. Chapter 6: Aligning fee-for-service payment rates across ambulatory settings.* https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

[16] Arnold Ventures. 2025. *New Research Brief Finds Billions in Savings for Seniors.* https://www.arnoldventures.org/stories/new-research-brief-finds-billions-in-savings-for-seniors

[17] Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, Brian Briscombe, Rose Kerber, Brenna O'Neill, Aaron Kofner. 2024. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative.* https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

tax on consumers and employers in the form of rising premiums and out-of-pocket costs, including high deductibles.[18] Given these high costs, nearly half of Americans in 2025 reported difficulties affording their health care costs.[19]

**Arnold Ventures supports the Administration's efforts to advance greater price transparency.** Unlike in most other markets, patients, employers, and other health care purchasers often have to make decisions without clear pricing information. Consumers simply should have access to such information before they seek health care services. Furthermore, reliable price data is essential to revealing the high and rising prices charged by hospitals and the widespread variation in prices for the same services within markets and hospitals – as well as the role of consolidation and provider market power in driving this variation. While the evidence suggests that price transparency alone is likely not sufficient to reduce prices, such data can inform purchaser efforts to negotiate lower prices and enables researchers and policymakers to develop policy solutions to improve health care affordability.[20]

Below, we provide comment on proposed provisions and recommend additional steps to strengthen the Hospital Price Transparency requirements.

**Enhanced Enforcement**: We appreciate the Administration's efforts to improve compliance with the Hospital Price Transparency rules. While the Hospital Price Transparency rules have been an important step forward to make hospital price transparency data available for patients, employers, and researchers, hospital compliance with the requirements continues to fall short. For example, an HHS Office of the Inspector General analysis in 2024 estimated that 46 percent of hospitals subject to the requirements did not fully comply.[21] **To improve compliance, we encourage the Administration to consider additional changes to strengthen enforcement beyond those included in the proposed rule.** Specifically, to strengthen enforcement, we recommend several changes to penalties for noncompliance with the requirements, including increasing the daily noncompliance penalties (scaled by hospital size; for example, up to $25 per bed per day for hospitals with 500+ beds), raising the maximum penalties for persistent noncompliance (for example, up to $10,000,000 for the largest (500+ beds) hospitals), reassessing penalties regularly over time, and increasing the penalties over time as appropriate to ensure strong and continued compliance from hospitals.

**Posting Prices in Dollars and Cents**: **The Administration should require hospitals to display all negotiated rates and cash prices in dollars and cents, rather than in algorithms or Medicare percentages.** We believe it is critical that prices be displayed consistently in this manner to improve the usability of the data for patients, purchasers, and researchers, including by improving their ability to compare prices across hospitals.

**Required Attestations. We support CMS's proposal to replace the "affirmation" standard with a more robust "attestation" designated in the machine-readable files by hospital leadership, including an attestation that hospitals have included all applicable payer-specific negotiated charges that can be expressed in dollars.** This requirement appropriately enhances executive accountability in ensuring transparent pricing information for the public.

**Inclusion of National Provider Identifiers (NPIs): We support the proposed requirement for hospitals to report their National Provider Identifiers (NPIs) in their machine-readable files (MRFs).** We agree with CMS

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[18] KFF. 2024. *Employer Health Benefits: Annual Survey 2024.* https://www.kff.org/health-costs/2024-employer-health-benefits-survey/.
[19] KFF. 2025. *Americans' Challenges With Health Care Costs.* https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/
[20] Glied, Sherry. JAMA Forum. 2021. *Price Transparency—Promise and Peril.* https://jamanetwork.com/journals/jama/fullarticle/2778818?resultClick=1.
[21] Department of Health and Human Services, Office of the Inspector General. 2024. *Not All Selected Hospitals Complied With the Hospital Price Transparency Rule*. https://oig.hhs.gov/reports/all/2024/not-all-selected-hospitals-complied-with-the-hospital-price-transparency-rule/.

that this will improve the comparability of the data to the Transparency in Coverage MRFs. More broadly, we are also supportive of proposals to enhance site-of-service billing transparency by requiring every off-campus HOPD to have a unique NPI.

We look forward to continuing to work with you on these important issues, and are available for further discussions on the above. Please contact Erica Socker, Vice President, Health Care (ESocker@arnoldventures.org) and Mark Miller, Executive Vice President, Health Care (MMiller@arnoldventures.org) with any questions.

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