

September 15, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1834-P)

Dear Administrator Oz,

Thank you for the opportunity to comment on the CY 2026 OPPS and ASC proposed rule. The 32BJ Health Fund is an unusually effective collaboration between a labor union and management to provide affordable, comprehensive, and innovative health coverage to working-class people. We aggregate employer contributions from 5,000 employers, ranging from many small businesses to global real estate firms, and use these contributions to provide benefits to 200,000 members of the SEIU Local 32BJ union and their families. The union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food service workers, and airport workers in over 10 states and Washington, DC.

The 32BJ Health Fund is a collectively bargained and self-insured multiemployer plan. While it contracts with vendors, such as third-party administrators (TPA) to provide benefits to plan participants, the 32BJ Health Fund itself is ultimately responsible for creating and implementing a cost-effective plan design that will allow its plan participants to access needed healthcare services while ensuring that costs to plan participants and the 32BJ Health Fund remain affordable.

Medicare payment methods and fee schedules have significant ripple effects for commercial plans like ours. Medicare rates are one of the most widely accepted benchmarks to evaluate provider reimbursements in the commercial healthcare market.¹ In addition to benchmarking, commercial rates may also be determined by referencing Medicare rates, such as establishing contracted commercial rates at a percentage of Medicare rates (often called “reference-based pricing”). As CMS points out in this proposed rule, addressing providers’ financial incentives to direct patients to more costly settings for care is a critical step to reduce increasing hospital

¹ Milliman (June 19, 2024). *Commercial reimbursement benchmarking: Commercial payment rates for medical services as percentage of Medicare fee-for-service rates*. <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates>

prices for employer purchasers and individuals seeking care. Furthermore, due to its size as the largest single payer for healthcare, Medicare's rates have a material impact on the shape of the market in terms of what settings and services are available, and at what price points.

Since 2004, the cost of health benefits for our participants has increased from 17% of the total employee compensation package to 37%. Put another way, healthcare costs have risen four times that of wages: with a 54% increase in wages and a 230% increase in health benefit costs. While many factors drive the rising cost of healthcare, our data -- and that of others -- consistently points to one overwhelming contributor: rising hospital prices. No other factor has a greater impact on healthcare costs. Our Health Fund spends about \$1.5 billion on healthcare each year, and over half of that spending is on hospital care. The hospital prices that 32BJ Health Fund pays in New York State have risen from 218% of Medicare in 2016 to 260% of Medicare in 2023. If the Health Fund paid the same rates that Medicare does for hospital services from 2016 to 2019, it could have saved \$1.1 billion.²

In recent years, spending increases are being driven by the hospital outpatient sector. In 2019, we spent roughly equivalent amounts on hospital inpatient and outpatient services. But from 2019-2023, our hospital inpatient spending decreased by 6% while hospital outpatient spending increased by 25%. In addition to outpatient spending increases, certain basic outpatient services, like flu shots, x-rays, or MRIs, have shifted from the historical norm of being provided in a doctor's office to being provided in more costly hospital outpatient departments. For example, in 2016, 71% of non-emergency CT scans for our participants in New York occurred in doctor's offices, with 29% in a hospital outpatient department. By 2022, nearly 41% of CT scans were occurring in a hospital outpatient department. There is no apparent clinical reason for this shift. This is particularly worrisome because the average hospital outpatient department price for a CT scan in our data is almost double that of a CT scan provided in a doctor's office. If non-emergency CT scans in New York hospital outpatient departments cost the same as those provided in a doctor's office, our Health Fund could have saved over \$500,000 in 2022.

Our comments address four specific components of the proposed rule, based on our practical experience as a healthcare purchaser: the site-neutral drug administration proposal (rule section X.A), Request for Public Comment - Other Methods to Control Volume of Covered OPD Services (rule section X.A.6), Request for Information (RFI): Adjusting Payment Under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings (rule section X.B)), and Updates to Requirements for Hospitals To Make Public a List of Their Standard Charges (rule section XIX).

² 32BJ Health Fund. (Revised November 1, 2022.) Hospital Prices: Unsustainable and Unjustifiable. https://32bjhealthinsights.org/wp-content/uploads/2022/12/HospitalPrices_screen-pages-final.pdf

Unless otherwise cited, all data provided in this public comment are from 32BJ Health Fund claims data analyses.

Section X.A. Site-Neutral Drug Administration Proposal: Nonrecurring Policy Changes Method To Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

Site-neutral payment is a key policy lever to disincentivize hospital acquisition of physician offices to convert to more expensive hospital outpatient departments (HOPDs) and to provide relief to employers and participants burdened with subsequent price increases. Given the concerning trends in increasing outpatient prices for routine care, enacting site-neutral payment is an important step to mitigate this price burden that is shouldered by employers and plan participants.

The 32BJ Health Fund supports the proposal to implement site-neutral payments for drug administration services in the OPDS. We urge CMS to consider adopting further site-neutral policies (e.g., widening the services set or widening the setting definition).

Section X.A.6 Request for Public Comment - Other Methods to Control Volume of Covered OPD Services

Question: Are there other services for which CMS should develop a method to control unnecessary increases in the volume of covered OPD services by paying a PFS-equivalent rate for services provided at excepted off-campus PBDs? Of particular concern for us are the services within the imaging without contrast APCs (APCs 5521–5524). Imaging without contrast services are some [of] the most costly and frequently provided services at excepted PBDs. We believe that there is a high likelihood that there has been unnecessary growth in this space and that a volume control method would be appropriate to apply here in the future. Would it be appropriate to apply this method to the Imaging Without Contrast APCs?

Response: Based on our claims data, we recommend CMS consider imaging without contrast APCs and additional services for site-neutral payment policy. Of services paid under the OPDS, many of the highest volume shifts we observe in our claims from the office to the hospital outpatient setting (HOPD) from 2018-2022 are for services within APCs for drug administration and imaging without contrast:

HCPCS	Service Description	APC	2018 HOPD Volume	2022 HOPD Volume
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Level 1 drug administration	14%	36%

70486	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL	Level 2 imaging w/o contrast	35%	48%
73560	RADIOLOGIC EXAMINATION, KNEE; 1 OR 2 VIEWS	Level 1 imaging w/o contrast	29%	42%
96415	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Level 2 drug administration	66%	77%

Other categories of services with volume shifts to consider are services within the Diagnostic Tests and Related Services APCs and Minor Procedures APCs. The services noted in our table above from 32BJ Health Fund claims data provide CMS an example of service location volume changes. We recommend CMS analyze these and other services commonly performed in HOPDs.

Section X.B. RFI: Adjusting Payment Under the OPSS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings

The rates Medicare pays for routine services in the OPSS and PFS fee schedules impacts the rates for those services paid by commercial healthcare payers. Implementing site-neutral payment for a broader range of services performed in the ASC, as the RFI discusses, provides an opportunity to remove financial incentives to drive care into more expensive settings. We are responding to select RFI questions based on observations of increasingly disparate site-differential pricing in our claims data to inform CMS’ broader development of Medicare site-neutral policies that also impact the commercial market.

Question 1. What items and services paid under the OPSS may have experienced unnecessary increases in volume? Should any policies that address those increases be more targeted to those services that have the most notable increases in volume indicative of shifting care from the ASC or physician office setting to the hospital OPD setting?

Response: Services with notable increases in volume due to shifting site of care should be targeted, but not to the exclusion of other services. Some services with smaller increases in HOPD volume may still be important to target if the service is a high volume or high-cost service, since even a moderate volume shift in such a service could have large spending implications. For example, we saw a small shift for diagnostic laryngoscopy (HCPCS 31575), from being done in the HOPD 6% of the time to 9% of the time, but the payment differential

across settings is large, and the service is relatively common, leading to larger financial impact for our Health Fund.

Question 4: In determining the setting in which a service is performed most frequently, should we use the most recent data available or should we use data that is 5 or even 10 years prior to the rate-setting year?

Response: We recommend using data that is 15 years prior to the rate-setting year, with the complement of more recent data as a secondary source. We agree with the importance of addressing the accumulation of past unnecessary increases in volume rather than allowing that shift and the underlying financial incentive that caused it to remain permanent.

The unique incentive for vertical consolidation addressed here began with the creation of the OPSS fee schedule in a hospital prospective payment silo, without attention to equivalent PFS rates for services provided in both settings. Because this issue was created administratively, its start date is straightforward, beginning in OPSS's first year of implementation in 2000.

From 2002-2008, the share of physician practices owned by hospitals more than doubled,³ and MedPAC began recommending site-neutral payments for ambulatory surgery as early as 2004, essentially immediately recognizing the issue created by site differential payments in OPSS and ASCs.⁴ GAO analysis of 2007 to 2013 data found vertical consolidation of physicians' offices again nearly doubling, leading to medical expenditures for HOPD services increasing 8.3% annually, versus 5.8% annual growth rate for total Medicare Part B spending and 2.4% for the national economy.⁵ Consolidation accelerated in 2010,⁶ and from 2010-2018 the share of integrated PCPs once again nearly doubled.⁷

Using data from at least 2010 (15 years prior to the rate-setting year) enables a more accurate identification of services that are typically and safely done in the office setting. In our own claims data, we identified shifts in the share of service volumes from office to HOPDs since the earliest year for which we have robust enough data available –2018. Using the most recent data or even data that is 5 years prior (e.g., 2020) would inappropriately identify some services as requiring HOPD-level resources and ossifying related healthcare cost inflation. For example, for the imaging without contrast service HCPCS 70486, we see an increase in the HOPD setting

³ Kocher R , Sahni NR . Hospitals race to employ physicians—the logic behind a money-losing proposition. *N Engl J Med.* 2011 ; 364 (19): 1790 – 3 .

⁴ Medicare Payment Advisory Commission (March 2004). Report to the Congress Medicare Payment Policy. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar04_Entire_reportv3.pdf

⁵ United States Government Accountability Office (2015). Increasing hospital–physician consolidation highlights need for payment reform. *GAO Report to Congressional Requesters.* <https://www.gao.gov/assets/gao-16-189.pdf>

⁶ Id.

⁷ Encinosa W, Nguyen P. Is the Recent Surge in Physician-Hospital Consolidation Finally Producing Cost-Savings? *J Gen Intern Med.* 2022 Dec;37(16):4289-4291. doi: 10.1007/s11606-022-07634-x. Epub 2022 Apr 27. PMID: 35477857; PMCID: PMC9708988.

from 35% to 48% from 2018 to 2022. Assuming this percentage has continued to climb, this service would be missed despite seeing a large volume shift.

Of course, more recent-year data could be used as a complement to check if any of the services captured by the 15-year look back data, and not by the recent data, demonstrate value-promoting reasons for the shift, and therefore, should continue to be incentivized with a higher payment rate.

Section XIX. Updates to Requirements for Hospitals To Make Public a List of Their Standard Charges

Our comments regarding CY2026 OPPS proposals related to hospital price transparency data build upon our recent submission to CMS' July 2025 Request for Information on Hospital Price Transparency Accuracy and Completeness and our September 2023 response to CMS-1786-P. Hospital machine-readable files (MRFs) inform 32BJ Health Fund's direct contracting negotiations and member benefit design efforts.

The 32BJ Health Fund supports regulatory efforts to improve hospital price transparency data accuracy and completeness, bolster enforcement actions for large hospital systems, and enhance public compliance reporting. As a self-insured fund, improving and enhancing publicly available hospital price transparency data is critically important for us to be able to benchmark and validate the prices we pay for healthcare services.

As a purchaser of healthcare services, we have extensive practical experience with the challenges and opportunities of using hospital price transparency data. These include persistent JSON parsing errors, inability to identify which commercial plan in MRFs reflects our plan structure, and missing data for services we know hospitals provide. We encourage CMS to consider our specific recommendations submitted in the 32BJ Health Fund July 2025 response to also inform potential adoption of the CY2026 OPPS proposed requirements for hospitals to publish standard charges data.

Conclusion

We urge CMS to continue its efforts to advance the quality and enforcement of hospital price transparency data and to support employer sponsored plans like the 32BJ Health Fund and its participants by addressing Medicare site-based differences in the price of routine care.

Thank you again for the opportunity to provide input during the public comment period. We appreciate the agency's consideration of the 32BJ Health Fund's perspective as you review all comments received.

Respectfully submitted,



Cora Opsahl Director, 32BJ Health Fund