AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

August 27, 2026

The Honorable Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically

RE: Calendar Year 2027 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (CMS-1850-P)

Dear Administrator Oz:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we submit these comments in response to the Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System proposed rule, published in the Federal Register on July 7, 2026. AMRPA is the national trade association representing more than 800 freestanding inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals, collectively referred to by Medicare as inpatient rehabilitation facilities (IRFs). Our members provide intensive, hospital-level rehabilitation to patients recovering from serious illnesses and injuries, including stroke, traumatic brain injury, spinal cord injury, amputation, and other complex conditions.

AMRPA's comments focus exclusively on the Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency Data. CMS seeks feedback on potential future changes to the information hospitals report in machine-readable files and consumer-friendly displays, including complex contracting terms, payer and plan identifiers, shoppable services, price estimator tools, and ancillary and bundled services. The RFI does not itself establish new reporting requirements.

AMRPA supports meaningful price transparency that provides patients with clear and useful information. However, future requirements should recognize that inpatient rehabilitation care is highly individualized, generally not scheduled far in advance, and rarely amenable to traditional price shopping. New requirements should be tailored to the clinical and operational realities of specialized hospitals and should not impose duplicative reporting or require disclosure of detailed proprietary information that does not help patients understand their expected costs.

I. Applicability of Price Transparency Requirements to Inpatient Rehabilitation Services

As AMRPA has explained in prior comments, the consumer-shopping framework underlying hospital price transparency requirements does not fit the core services furnished by IRFs. Most IRF patients are admitted directly from an acute care hospital following a serious illness, injury, surgery, or other major medical event. Admission decisions may need to be made promptly and depend on the patient's medical stability, functional impairments, rehabilitation needs, ability to participate in intensive therapy, and the availability of a rehabilitation program.

Patients and families generally do not have the same opportunity to schedule and compare a standardized rehabilitation service across hospitals that they may have for an elective outpatient procedure. For many patients, the immediate question is whether an IRF can safely accept the patient and provide the necessary level of care, not whether the patient can shop among standardized rehabilitation services based on price.

The content and cost of an IRF stay also cannot be reduced to a list of discrete services. After admission, an interdisciplinary rehabilitation team evaluates the patient and develops an individualized plan of care. The mix and intensity of physical therapy, occupational therapy, speech-language pathology, rehabilitation nursing, physician services, medications, diagnostic services, equipment, and other care may change throughout the stay based on the patient's needs and progress.

For Medicare fee-for-service patients, these services generally do not result in separate facility payments based on the number or intensity of individual services furnished. Instead, Medicare pays IRFs under a prospective, per-discharge payment system that encompasses the routine, ancillary, and capital costs associated with the IRF stay, with payment determined by the patient's case-mix group (CMG) and applicable case- and facility-level adjustments. Physician and other professional services may be separately billed.

CMS asks whether it should revise the number and types of CMS-specified shoppable services. Requiring IRFs to display standardized rehabilitation packages could mislead patients by implying that the scope and cost of care are known before the individualized assessment and planning process has occurred. For Medicare patients, the clinical and functional information used to establish the patient's CMG is collected during the first three calendar days of the IRF stay. As a result, the final CMG-based payment classification is not available before admission when a patient and family may be considering post-acute care options.

AMRPA urges CMS not to add inpatient rehabilitation services to the CMS-specified list of shoppable services and to tailor future consumer-facing requirements for hospital types and services where advance price shopping is not clinically realistic.

II. Reporting of Complex Contracting Terms

CMS seeks feedback on how hospitals should report outlier payments, stop-loss provisions, rate-tiering arrangements, carve-outs, and other contracting adjustments. These provisions frequently do not establish a distinct negotiated price for an individual item or service.

For example, whether an outlier or stop-loss provision applies may depend on the patient's aggregate costs, clinical complexity, length of stay, or total course of treatment. A carve-out may apply to an entire category of services, while a rate-tiering arrangement may modify the overall terms applicable to a hospital or network. These provisions may therefore operate at the contract, service-category, case, or patient level rather than at the individual item or service level.

Requiring hospitals to repeat broadly applicable terms for every item or service would create substantial duplication and could make machine-readable file data less accurate and less usable. It could also incorrectly suggest that a contract-level provision applies independently to each listed service.

If CMS pursues additional standardization, hospitals should be permitted to identify the general type of provision, the level at which it applies, whether it may affect the final amount paid, and a concise explanation of when it applies. Broadly applicable provisions should be reported once at the appropriate contract or service-category level. CMS should also allow hospitals to indicate when a provision is not applicable, a dollar amount cannot be calculated in advance, or the hospital does not possess the information necessary to calculate a patient-specific amount.

CMS should retain an "other" category and a limited free-text field because complex contracts may combine multiple methodologies or include terms that do not fit within a standardized list. CMS should also avoid requiring disclosure of proprietary formulas, algorithms, thresholds, or other detailed contractual mechanisms beyond the information necessary to explain generally how a reported charge may be adjusted. Such granular information is unlikely to help patients make care decisions and may instead be used primarily by commercial parties during contract negotiations.

AMRPA urges CMS to require complex contracting terms to be reported only at the level at which they actually apply and not to require item-level reporting or granular disclosure of proprietary contractual formulas when those terms operate at the case, category, patient, or contract level.

III. Standardization of Payer, Plan, Product, Network, and Employer Information

AMRPA recognizes that inconsistent payer and plan naming conventions may make machine-readable files difficult to compare. Targeted standardization may improve the usability of hospital price transparency data. However, hospitals should not be responsible for developing or independently maintaining a national crosswalk among payer names, insurance products, networks, plans, and employers.

Payers are generally best positioned to identify their own products, plans, and networks and to provide standardized identifiers for those arrangements. CMS should work with payers and hospitals to identify an existing identifier or establish a CMS-maintained system that can be used consistently across contracts and machine-readable files.

Hospitals should be required to report only identifiers and information that are supplied by the payer or otherwise maintained in the hospital's ordinary contracting, billing, or remittance records. Hospitals should not be required to create unique identifiers, manually reconcile inconsistent payer terminology, or infer product and network information that a payer has not clearly provided.

Employer-level reporting warrants particular caution. Employer and benefit-plan information may not be available to hospitals in a consistent format and may change more frequently than payer or product information. Requiring hospitals to map employer-level information could create significant burden without improving the information available to most patients.

Before implementing new identifiers or structured fields, CMS should test them with a representative range of hospitals, including freestanding IRFs and hospital-based rehabilitation units. CMS should also publish complete technical specifications and provide hospitals and vendors with sufficient time to update their systems.

AMRPA urges CMS to rely on uniform payer-supplied or CMS-maintained identifiers, limit hospital reporting to information available in the ordinary course of business, and avoid employer-level reporting requirements unless a standardized identifier is readily available and necessary to distinguish the applicable negotiated charge.

IV. Deemed Compliance Through Internet-Based Price Estimator Tools

CMS asks whether it should modify or eliminate the policy under which a hospital is deemed compliant with the consumer-friendly display requirements when it maintains an internet-based price estimator tool.

A price estimator tool may provide patients with more useful and individualized information than a static shoppable-services file. Depending on the tool and available data, it may account for the patient's insurer, plan, deductible, benefit design, and expected cost-sharing responsibilities. A standardized file may improve comparability across hospitals, but it generally cannot provide the patient-specific estimate that consumers most often seek.

Variability among estimator tools does not necessarily justify requiring every hospital to maintain both an estimator tool and a separate shoppable-services file. CMS could establish reasonable baseline expectations for consumer-facing tools, such as clear website access, understandable service descriptions, identification of facility and professional charges, and

appropriate explanations of the limitations of an estimate. Hospitals should retain flexibility in how they satisfy those expectations.

CMS should also avoid requiring a separate underlying data file that substantially duplicates the comprehensive machine-readable file hospitals already maintain. Any additional file requirement should be limited to information that can be generated automatically and should not require disclosure of proprietary estimator-tool logic.

Differences between information presented through an estimator tool and information in an MRF may also reflect the distinct functions of the two formats. An estimator may incorporate patient-specific insurance and benefit information that is not included in a static file. CMS should distinguish between these legitimate differences and actual inconsistencies in the underlying standard-charge information.

AMRPA urges CMS to maintain the deemed compliance pathway for hospitals that offer internet-based price estimator tools and not require a duplicative shoppable-services file unless CMS demonstrates that doing so would meaningfully benefit patients without creating disproportionate burden for specialized hospitals.

V. Ancillary and Bundled Services

CMS seeks feedback on how hospitals should present ancillary items, bundled services, and information regarding services included in or excluded from a displayed price.

For Medicare fee-for-service patients, the IRF payment structure is already fundamentally case-based and bundled. Under the IRF PPS, the facility receives a prospective payment encompassing the routine, ancillary, and capital costs associated with the patient's stay, rather than separate facility payment for each therapy session, medication, diagnostic service, or other component of care.
For services that are commonly scheduled and standardized, information about included and excluded components may help consumers understand an estimate. In the IRF setting, however, ancillary services depend on the patient's condition, complications, functional needs, and response to treatment. Hospitals cannot reliably predict every diagnostic test, medication, physician consultation, item of equipment, or other service that may become necessary during an IRF stay. As discussed above, the applicable Medicare case-mix classification also cannot be finalized before admission, further limiting the usefulness of a standardized pre-admission bundle price.

Requiring IRFs to publish standardized packages or exhaustive lists of included and excluded services could imply a level of clinical certainty that does not exist. It could also make displayed prices less accurate by requiring hospitals to assume that all patients will receive the same combination of services.

Where an estimate is available, hospitals should be permitted to explain in plain language that it is based on information known at the time and may change according to the patient's individualized plan of care and medical needs. Hospitals should also be able to distinguish facility charges from professional charges and identify categories of services that may be billed separately without predicting services that have not yet been ordered. Hospitals should likewise be permitted to explain which services are generally encompassed by the facility payment.

AMRPA urges CMS to allow hospitals to explain the patient-specific nature of ancillary and bundled services and not require IRFs to publish standardized rehabilitation packages or exhaustive lists that could misrepresent the individualized nature and expected cost of care. CMS should also recognize the existing case-based and bundled nature of Medicare IRF payment when developing any future requirements related to bundled or ancillary services.

VI. Implementation of Any Future Requirements

AMRPA appreciates CMS's decision to seek stakeholder input before proposing additional requirements in this technically complex area. The current RFI does not impose new reporting obligations, and any new requirements should be presented in a future proposed rule with complete technical and operational details.

A future proposal should clearly identify the required data elements, reporting level, definitions, technical specifications, compliance standards, implementation timeline, and enforcement approach. CMS should also conduct a burden analysis that accounts for differences among hospital types and the cumulative effects of existing hospital price transparency requirements.

CMS should evaluate whether each proposed data element provides information that patients can realistically understand and use and whether the same objective could be achieved through a less burdensome approach. Specialized hospitals should not be required to divert clinical, financial, contracting, and information-technology resources toward reporting that does not meaningfully support patient decision-making.

AMRPA urges CMS to propose any new hospital price transparency requirements through notice-and-comment rulemaking, conduct a provider-specific burden analysis, and provide hospitals with sufficient implementation time following publication of complete technical specifications.

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AMRPA appreciates CMS's consideration of these comments and looks forward to continued engagement on policies that provide patients with useful information while preserving access to high-quality inpatient rehabilitation care. If you have any questions regarding our comments,

please contact Kate Beller, AMRPA President, at kbeller@amrpa.org and Emily Green-Conrad, Director of Government Relations & Policy, at egreenconrad@amrpa.org.

Sincerely,

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