CHILDREN'S HOSPITAL ASSOCIATION

May 11, 2025

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

Dear Administrator Oz,

As the nation's leading advocate for children's health, the Children's Hospital Association (CHA) writes to urge the Centers for Medicare & Medicaid Services (CMS) to use its discretionary implementation authority to exempt children's hospitals with minimal Medicare utilization from the new off-campus outpatient department National Provider Identifier (NPI) and provider-based attestation requirements enacted under Section 6225 of the *Consolidated Appropriations Act, 2026*. Given children's hospitals de minimis Medicare footprint and disproportionate administrative burden these requirements would impose, applying this policy uniformly would create significant operational challenges and potential barriers to pediatric care access without meaningfully advancing Medicare transparency or program integrity efforts.

Children's Hospital Outpatient Departments are Distinct

Children's hospitals deliver highly specialized pediatric services through hospital outpatient departments (HOPDs) that extend comprehensive care into communities, improving access for children and families, particularly in rural and underserved areas. These sites often serve children with specialized, medically complex, and chronic conditions who require coordinated, multidisciplinary care. Unlike typical physician offices, children's HOPDs are supported by specialized staff, advanced infrastructure, integrated care coordination, and services such as pharmacy, behavioral health, nutrition support, and on-site diagnostics, including imaging and laboratory services. Often these outpatient departments see patients referred by physician offices that require diagnostic or other specialized tests or care.

While children's hospitals are subject to the Medicare Hospital Outpatient Prospective Payment System (OPPS) for outpatient services, Medicare represents a negligible share of their patient population, often less than 3% overall, and often close to zero for HOPDs. As a result, the NPI and attestation requirements would impose substantial operational burden on children's hospitals without producing meaningful Medicare programmatic benefit. In addition, when adopted under Medicare, other payers often apply these requirements to children without analyzing the unique impact of these requirements on care that is more regionalized with fewer options for specialized care in comparison to adults.

Administrative Burden

Children's hospitals consistently report that compliance with the NPI and attestation requirements would require substantial staffing, time, and financial resources. Hospitals have estimated implementation would require multi-full time equivalent (FTE) staffing, with some reporting more than 5 dedicated FTEs and total costs approaching $1 million. Some children's hospitals operate dozens of outpatient departments and

affiliated clinics, significantly magnifying the scale, complexity, and cost of compliance. Implementation timelines are lengthy—often 6 to 12 months—and each attestation can take weeks to months to complete, particularly for hospitals with multiple outpatient sites

The attestation process is complex and difficult to operate at scale. While children's hospitals ensure their off-campus outpatient departments meet applicable provider-based requirements, attestations have not been previously required in this manner. Gathering the data and documentation necessary to support these requirements would impose significant administrative burden on children's hospitals without meaningfully advancing Medicare program objectives given the limited Medicare utilization in pediatric settings. Separate NPI requirements would require substantial operational and billing changes, including internal coordination, billing system reconfiguration, workflow design, and ongoing compliance tracking across multiple outpatient locations.

For many children's hospitals, existing billing and administrative infrastructure is not currently designed to support these requirements and will require significant systems development and operational restructuring. Hospitals also report ongoing challenges navigating inconsistent guidance and responsiveness from Medicare Administrative Contractors (MACs), creating additional uncertainty as hospitals attempt to plan for compliance. Children's hospitals further emphasized that communicating and operationalizing these changes with external payers is a lengthy and resource-intensive process. This includes updating payer contracts, recredentialing physicians and locations, modifying claims submission systems, and ensuring alignment between internal operations and payer requirements. Many children's hospitals emphasized that even facilities with experience submitting these attestations would face similar challenges under these new requirements due to scale and complexity of the process, as they do not have the existing infrastructure and processes to accommodate these changes by the proposed January 2028 implementation timeline.

Impacts on Access to Care and Coordination

Beyond administrative burden, children's hospitals are deeply concerned that these requirements are the first step toward broader payment and policy changes that could further threaten access to the specialized care provided through outpatient services. Pediatric care often relies on integrated, systems-based models that allow providers to coordinate services across multiple sites. The NPI and attestation requirements introduce new barriers to this coordination increasing the risk of billing errors, claim denials, and prior authorization challenges.

Children's hospitals also report that the policy could constrain their ability to adapt care delivery models to meet patient needs. Requirements tied to specific locations may limit flexibility to move services between sites, expand clinic footprints to serve a broader area of patients, or respond to growing demand for pediatric health care services. Over time, these added operational and financial pressures may reduce children's hospitals' ability to sustain and expand community-based outpatient services that bring specialized care closer to patients' homes. For children with medically complex and chronic conditions—particularly those in rural and underserved communities—this could delay access to timely care, reduce availability of specialty providers and services, and place critical pediatric outpatient access points at greater risk. Furthermore, children's hospitals are concerned about potential downstream implications these requirements may have for other hospital outpatient policies and operational frameworks, including

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uncertainty regarding impacts on programs—such as the 340B Drug Pricing Program—that support access and the financial sustainability of pediatric outpatient services.

We appreciate your consideration of these concerns and look forward to working with CMS to support an implementation approach that advances CMS's transparency and program integrity goals while minimizing unnecessary burden on children's hospitals and preserving access to care for children.

Sincerely,

Aimee C. Ossman

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VP, Policy

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