MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Betty Rambur, Ph.D., R.N., F.A.A.N., Vice Chair
Paul B. Masi, M.P.P., Executive Director

June 9, 2025

Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1833-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes," *Federal Register* 90, no. 82, pp. 18002–18491 (April 30, 2025). We appreciate CMS's ongoing efforts to administer and improve Medicare's payment systems for hospitals, particularly given the many competing demands on the agency's staff.

Our comments focus on CMS proposals to, in fiscal year (FY) 2026:

- update inpatient prospective payment systems (IPPS) payment rates;
- update wage index values and policies;
- modify the Transforming Episode Accountability Model (TEAM); and
- remove the proposed health-equity adjustment from the Hospital Value-Based Purchasing (VBP) Program.

Proposed update to IPPS payment rates

For FY 2026, CMS proposes to increase the IPPS operating payment rate by 2.4 percent and the IPPS capital base rate by 2.6 percent.

Comment

We understand that the Secretary does not have the authority to deviate from statutorily mandated updates and that, therefore, CMS is required to implement this statutory update to the IPPS operating payment rate and is following longstanding policy regarding updates to the IPPS capital payment rate. However, we appreciate that CMS cited our March 2025 recommendation to, for 2026, update the 2025 hospital payment rates by the amount specified in current law plus an additional 1 percent and redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI) and add $4 billion to the MSNI pool.[1] We made this recommendation after reviewing many indicators of payment adequacy, including beneficiary access to hospital services, the supply of hospitals, quality of care provided to beneficiaries, access to capital, and fee-for-service Medicare payments and hospitals' costs overall and for a subset of hospitals identified as relatively efficient (relatively lower costs and higher quality of care). These hospital payment-adequacy indicators were mixed, though a subset improved relative to last year. In addition, hospitals that treat larger shares of low-income Medicare patients continued to face larger financial challenges. The MSNI would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges.

Proposed update to wage index values and policies

For FY 2026, CMS proposes to continue existing IPPS wage index policies from FY 2025, including:

- using the post-reclassification, post-floor wage index;
- updating the wage index with newer wage data and Office of Management and Budget (OMB) labor market area delineations;
- capping the wage index decrease a provider can experience in a given year at 5 percent; and
- discontinuing the low-wage-index policy and extending a transition policy for FY 2026.

Comment

The Commission supports CMS's annual process to update the IPPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap the wage index decreases that a provider can experience in a given year. We continue to urge

[1] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

CMS to apply a cap to the wage index increases that a provider can experience in a given year as well.

However, the Commission has long been concerned with flaws in the wage index system that Medicare uses to adjust IPPS payments to reflect geographic differences in labor costs.[2] These concerns have continued to grow along with the rise in the number of reclassifications. (In the proposed rule, CMS estimates that about 36 percent of IPPS hospitals will have active reclassifications with the Medicare Geographic Classification Review Board in FY 2026, including 279 with dual-reclassifications to a rural area and then back to their original urban geographic area.)

To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, skilled nursing facilities), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's June 2023 report to the Congress, we recommend that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

Modification of the Transforming Episode Accountability Model

CMS proposes various technical changes to the Transforming Episode Accountability Model (TEAM), which is a new episode-based payment model that will be mandatory in certain areas of the U.S. in 2026 through 2030 and was finalized in last year's rule. CMS also solicits comments on a few TEAM topics, including the requirement that TEAM providers refer all attributed Medicare beneficiaries to a primary care provider (PCP) to provide longitudinal care after TEAM's episodes have ended. CMS explains that "Since a TEAM episode only lasts 30 days after the TEAM beneficiary is discharged from the hospital, the goal of this policy is to integrate care during the transition from an acute event—an episode—back to longitudinal care relationships, such as primary care."

---

[2] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Comment

In our June 2024 comment letter, the Commission supported TEAM, which is directionally consistent with our June 2022 report encouraging CMS to implement a new mandatory episode-based payment model, as a complement to population-based payment models (e.g., accountable care organizations (ACOs)).[3] We note that coexisting ACOs and episode-based payment models should interact synergistically. It will be important for CMS to monitor the effects of TEAM and its overlap with ACOs, since it would result in two different advanced alternative payment models holding two sets of providers accountable for spending by a single beneficiary.

In addition, the TEAM design should avoid conflicting with the primary care–based design of ACOs, including patient assignment. We therefore urge caution in pursuing the requirement to refer patients to PCPs. CMS reports that 94 percent of beneficiaries in a predecessor episode-based payment model already had a PCP that they had obtained care from in the prior two years. We are thus concerned that requiring TEAM participants to refer patients to a new PCP rather than encouraging beneficiaries to return to their existing PCP could cause confusion for some beneficiaries (who may believe they need to begin seeing the new PCP instead of, or in addition to, their existing PCP) and may result in care fragmentation.

We note that the Medicare conditions of participation for hospitals already require these facilities to notify the patient's established PCP when the patient is admitted or discharged from the inpatient setting of the hospital (42 CFR 482.24(d)). As this requirement is already in place, this information could be used to identify those patients who do not already have a PCP and may benefit from establishing a usual source of care.

We also note that Medicare's physician fee schedule payments for the surgical procedures included in TEAM generally take the form of global codes that include payment for a certain number of postoperative visits that are assumed to be provided by the billing surgeon or another clinician in the surgeon's practice in the 90 days following a surgical procedure. It's unclear how TEAM's PCP referral requirement would align with the postoperative visits that Medicare pays surgeons to provide in the 31st to 90th day following an episode through those global codes.[4]

Given the potential for this requirement to result in double payment for postoperative visits, care fragmentation, and disruption to beneficiary assignment in ACOs, we suggest that TEAM providers (1) only offer referrals to new PCPs to beneficiaries who report

---

[3] Medicare Payment Advisory Commission. 2022. "An approach to streamline and harmonize Medicare's portfolio of alternative payment models," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch1_MedPAC_Report_to_Congress_SEC.pdf.

[4] When a surgeon or another clinician in their practice does not provide the postoperative visits in the 90 days following a procedure, they are supposed to flag this for CMS so their global payment can be reduced, but CMS has previously noted that this rarely occurs.

having no PCP when they are asked about this and (2) identify which clinician a beneficiary should schedule their postoperative visits with in the 90 days following their procedure.

Removal of the proposed health-equity adjustment in the Hospital VBP adjustment from the scoring of hospital performance

The Hospital VBP creates incentives for providers to furnish high quality of care. Under the Hospital VBP program, CMS redistributes a pool of dollars equal to 2 percent of adjusted operating base payments based on performance on a set of outcome, patient-experience, safety, and efficiency measures. In the FY 2024 final rule, CMS added a health-equity adjustment (HEA) that, beginning in FY 2026, would reward top-performing hospitals that serve higher proportions of patients with dual eligibility status.

In this year's proposed rule, CMS intends to remove the HEA from the scoring of hospital performance. CMS said the removal would improve hospitals' understanding of the VBP program and provide clearer incentives for hospitals to improve the quality of care for all patients. CMS considered altering the structure of the adjustment methodology to simplify it but said this would take time to test and develop and, if pursued, would be addressed in future rulemaking.

Comment

In its June 2023 comment letter on the proposed HEA, the Commission supported CMS's efforts to account for differences in the social risk of provider patient populations in the Hospital VBP scoring.[5] Though structured differently, the HEA is consistent with one of the Commission's principles of measuring quality in the Medicare program: The program should take into account, as necessary, differences in a provider's patient population, including social risk factors.[6] Providers that treat higher proportions of patients with dual eligibility may face greater challenges to success in a quality payment program because it may be harder for them to achieve good outcomes for their patients. A quality payment program, such as the Hospital VBP program, should account for differences in the providers' patient populations to counter the challenges they could face in achieving good outcomes.

If the HEA is removed, the Commission encourages CMS to consider an alternative design that the Commission recommended in its March 2019 report. We recommended that the Congress replace Medicare's current hospital quality programs, including the Hospital VBP, with a new hospital value incentive program that accounts for differences in patients'

---

[5] Medicare Payment Advisory Commission. 2023. MedPAC comment on CMS's proposed rule entitled: "Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership." June 9. https://www.medpac.gov/wp-content/uploads/2023/06/06092023_FY_2024_IPPS_LTCH_MedPAC_Comment_v2_SEC.pdf

[6] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

social risk factors by distributing payment through a peer-grouping approach.[7] In this design, Medicare would make adjustments to payments based on a provider's performance compared with providers with similar mixes of patients at high social risk (that is, its "peers") to determine the penalties or rewards based on its performance. Medicare would continue reporting unadjusted performance so that patients and other stakeholders would have information to inform their decisions. In its report to the Congress, the Commission included additional considerations for how to structure the hospital value incentive program.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[7] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.