MEDPAC | Medicare Payment Advisory Commission

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
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Attention: CMS-1834-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 and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency," *Federal Register* 90, no. 135, pp. 33476–33865 (July 17, 2025). We appreciate CMS's ongoing efforts to administer and improve Medicare's payment systems for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs), particularly given the many competing demands on the agency's staff.

Our comments focus on CMS proposals to, in calendar year (CY) 2026:

- update outpatient prospective payment system (OPPS) payment rates,
- update OPPS wage index values and policies,
- extend use of the hospital market basket to update ASC payment rates,
- phase out the inpatient-only list and correspondingly increase the ASC covered-procedures list,
- expand site-neutral payments for drug administration and request information on potential future expansions,
- unbundle skin substitutes in the OPPS and pay at site-neutral rates in Medicare's physician fee schedule,
- solicit comments on payment policy for software as a service, and
- use Medicare Advantage data to update relative weights under the inpatient prospective payment systems (IPPS).

Proposed update to OPPS payment rates

For CY 2026, CMS proposes to update the OPPS payment rate by the same amount as the IPPS operating payment rate for fiscal year (FY) 2026.

Comment

We understand that the Secretary does not have the authority to deviate from statutorily mandated updates. 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 (FFS) 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 CY 2026, CMS proposes to generally continue existing OPPS wage index policies from CY 2025, and to adopt the same wage index values as in the FY 2026 IPPS proposed rule.

Comment

The Commission supports CMS's annual process to update the OPPS wage index with newer wage data and Office of Management and Budget 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 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 CMS uses to adjust IPPS and OPPS 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

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

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 and OPPS 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 recommended 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.

Extended use of the hospital market basket to update ASC payment rates

Before CY 2019, CMS annually updated the ASC payment rate using the Consumer Price Index for All Urban Consumers (CPI–U). Beginning in CY 2019, CMS has updated payment rates in the ASC payment system using the hospital market basket (MB) minus a productivity adjustment, the same rate update mechanism used in the OPPS. When the agency first implemented this new policy, it did so for a five-year period (CY 2019 through CY 2023), with the intent of encouraging the migration of services from HOPDs to the ASC setting while the agency assessed the feasibility of collecting ASC cost data in a minimally burdensome manner.[3] However, CMS has not reported on the findings of its feasibility study, and in the CY 2024 final rule, the agency extended the use of the hospital MB to update ASC payment rates for two additional years (through CY 2025).[4]

For CY 2026, CMS proposes extending the use of the hospital MB for an additional year (through CY 2026).

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[3] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program: Changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs. *Federal Register* 83, no. 225 (November 21): 58818–59179.

[4] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems; quality reporting programs; payment for intensive outpatient services in hospital outpatient departments, community mental health centers, rural health clinics, federally qualified health centers, and opioid treatment programs; hospital price transparency; changes to community mental health centers conditions of participation; changes to the inpatient prospective payment system Medicare code editor; rural emergency hospital conditions of participation technical correction. *Federal Register* 88, no. 224 (November 22): 81540–82185.

Comment

In the Commission's comments on the CY 2019 and 2024 OPPS/ASC proposed rules,[5] we expressed opposition to using the hospital MB as an interim method for updating the ASC payment rates. While the use of the hospital MB is an improvement over the CPI–U, we continue to urge CMS to instead move to using data reflective of ASCs' costs. Evidence indicates that the hospital MB index does not accurately reflect the costs of ASCs. In the CY 2019 proposed rule, CMS acknowledged that ASCs' cost structure likely differs from that of hospitals, in part because ASCs tend to be single specialty, for profit, and are not required to comply with the Emergency Medical Treatment and Labor Act (EMTALA). In addition, relative to hospitals, ASCs are more urban, serve a different mix of patients demographically and by payer type, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs.

As we noted in the Commission's comments on the CY 2024 proposed rule,[6] analysis of ASC and HOPD service volume indicates that surgical procedures were already migrating from HOPDs to ASCs before CMS implemented the use of the hospital MB in CY 2019. Therefore, we conclude that increasing the ASC payment rates by updating them with the hospital MB was not necessary to encourage surgical procedures to migrate from HOPDs to ASCs, nor is it necessary for CMS to collect additional data on the effects of using the MB update on ASC volume.

Rather, CMS should collect targeted cost data from ASCs and use it to construct an ASC-specific MB, as the Commission recommended from 2010 to 2022 and recently discussed in our March 2025 report to the Congress.[7]

Proposed phaseout of the inpatient-only list and increase to the ASC covered-procedures list

The inpatient-only (IPO) list is a list of Healthcare Common Procedure Coding System (HCPCS) codes that are typically provided in an inpatient setting and cannot be paid under the OPPS. The IPO list currently comprises 1,731 HCPCS codes. CMS has previously received comments from stakeholders recommending that CMS eliminate the IPO list, while other stakeholders have recommended that CMS should maintain the list. Those who advocate for the elimination of the IPO list argue that regulations should not supersede physicians' knowledge and assessments of their patients' conditions and that physicians can appropriately determine whether a procedure can be performed safely in the hospital outpatient setting. In addition, excluding services from coverage under the OPPS could have an adverse effect on advances in surgical care. Stakeholders who advocate for the

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[5] Medicare Payment Advisory Commission. 2018. Comment letter on CMS's 2019 proposed rule for the hospital outpatient and ambulatory surgical center payment systems, September 21.
Medicare Payment Advisory Commission. 2023. Comment letter on CMS's proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for 2024, September 11.
[6] Medicare Payment Advisory Commission. 2023. Comment letter on CMS's proposed rule on the payment systems for hospital outpatient departments and ambulatory surgical centers for 2024, September 11.
[7] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

continuation of the IPO list consider it an important tool to determine which services are appropriate to furnish in the outpatient setting and to ensure that Medicare beneficiaries receive care in clinically appropriate settings. In addition, services included on the IPO list are excepted from the two-midnight rule and, therefore, are considered appropriate for inpatient admission and payment under Part A regardless of the expected length of stay.

In the CY 2021 rule, CMS finalized a policy to eliminate the IPO list over the course of three years.[8] As part of the first phase of this elimination of the IPO list, CMS removed 298 codes, including 266 musculoskeletal-related services, from the list beginning in CY 2021. However, in the CY 2022 rule, CMS halted the elimination of the IPO list and, after clinical review of the 298 codes removed from the IPO list in CY 2021, CMS returned most of the services back to the IPO list beginning in CY 2022.[9]

In this proposed rule, CMS asserts that the IPO list is no longer needed to distinguish the services that require inpatient care from those that can be provided safely in the outpatient setting. Physicians should use their clinical knowledge and judgment, together with the patient's specific needs, to determine the appropriate site of service. CMS also argues that there have been significant developments in the practice of medicine that have allowed numerous services to be safely and effectively provided in the outpatient setting. Finally, CMS argues that the combination of physician judgment, state and local licensure requirements, accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and CMS quality and monitoring initiatives and programs will continue to ensure the safety of patients in both the inpatient and outpatient settings, even in the absence of the IPO list. CMS proposes to phase out the IPO list over a three-year period, beginning January 1, 2026, and ending January 1, 2029.

For CY 2026, CMS proposes to remove 285 services from the IPO list, including 269 musculoskeletal services and 16 non-musculoskeletal services. CMS requests comment on whether three years is an appropriate time frame for the phaseout of the IPO list.

For CY 2026, CMS also proposes to revise their regulatory criteria to evaluate potential additions to the ASC covered-procedures list (CPL), similar to the changes they finalized in the CY 2021 rule and withdrew in CY 2022. The proposal would remove certain general standard and general exclusion criteria and move them to a new section as nonbinding physician considerations for patient safety. Under the revised criteria, CMS proposes to

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[8] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; new categories for hospital outpatient department prior authorization process; clinical laboratory fee schedule: laboratory date of service policy; overall hospital quality star rating methodology; physician-owned hospitals; notice of closure of two teaching hospitals and opportunity to apply for available slots; radiation oncology model; and reporting requirements for hospitals and critical access hospitals to report COVID-19 therapeutic inventory and ssage and to report acute respiratory illness during the public health emergency for coronavirus disease 2019. Federal Register 85, no. 249 (December 29): 85866–86305.

[9] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; price transparency of hospital standard charges; radiation oncology model; request for information on rural emergency hospitals. *Federal Register* 86, no. 147 (August 4): 42018–42360.

add 276 surgical or surgery-like procedures (that are not on the CY 2025 IPO list) to the ASC CPL, beginning in CY 2026, in order to expand access while maintaining the safety for Medicare beneficiaries through the nonbinding physician considerations for patient safety. Additionally, CMS proposes to add 271 surgery or surgery-like codes to the CPL that are currently on the IPO list, if the proposal to remove these services from the IPO list for CY 2026 is finalized.

Comment

The Commission understands CMS's motivation for this proposal to eliminate the IPO list but suggests that CMS should proceed cautiously. In the absence of the IPO list, the Commission agrees that, in general, clinicians will use their knowledge and judgment to provide patient care in the most appropriate setting. However, factors other than clinical knowledge and judgment, such as financial considerations, can affect these decisions. Therefore, the Commission urges CMS to monitor the effects of removing musculoskeletal services from the IPO list on patient outcomes before proceeding with additional changes.

With respect to the changes to the regulatory criteria and proposed additions to the ASC CPL, we also understand the motivation and urge similar caution. The Commission generally supports giving providers more autonomy in decisions about the appropriate clinical setting for providing surgical procedures, and we also encourage CMS to proceed carefully to ensure patient safety.

Proposed expansion of site-neutral payments for drug administration and request for information on potential future expansions

CMS states that there is evidence of continued growth of HOPD services driven by site-of-service payment differentials between the physician fee schedule (PFS) and the OPPS, which affect both the Medicare Trust Fund and Medicare beneficiaries' cost sharing liabilities. In the CY 2019 final rule, CMS adopted a method to control increases in the volume of the clinic visit services furnished in off-campus provider-based departments (PBDs) excepted from the site-neutral payments established in Section 603 of the Bipartisan Budget Act of 2015.[10]

In this proposed rule, CMS asserts that the effect of hospital–physician vertical integration and increased volume of outpatient services extends beyond clinic visits; therefore, the CY 2019 policy described above only addressed the financial incentive for one service type in one outpatient setting. In particular, the high volume of drug administration services and the magnitude of rate differences between the physician office and HOPD settings make it a family of services likely to migrate to a higher-paying setting of care. CMS has found increases in the volume of drug administration services over time, increases in the volume of services provided per beneficiary, and cases of significant volume growth for some

[10] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program: Changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs. *Federal Register* 83, no. 225 (November 21): 58818–59179.

individual HCPCS codes within the drug administration ambulatory payment classification (APC) family. As such, for CY 2026, CMS proposes to address site-of-service payment differentials by aligning Medicare's OPPS payments with rates paid under the PFS for drug administration services provided at excepted PBDs. These services include drug administration APCs 5691–5694, which comprise 61 HCPCS codes.

In addition, CMS requests information about expanding site-neutral payments to other families of services (imaging without contrast) and to other outpatient settings (on-campus outpatient clinic visits).

Comment

The Commission supports expanding site-neutral payments for drug administrative services that are provided in excepted off-campus PBDs.

In our June 2023 report to the Congress, the Commission recommended closely aligning payment rates across ambulatory settings for selected services that are safe and appropriate to provide in all settings when doing so does not pose a risk to access.[11] The Commission included an illustrative framework that could be helpful in identifying services for which it might be safe and appropriate to align payment rates, but CMS should consult with clinicians and industry stakeholders when making decisions about which services to choose. In addition, the site-neutral payments should not adversely affect hospitals' ability to be available 24/7 for emergency care, with particular attention paid to safety-net and rural providers. Finally, the packaging of ancillary items in the OPPS should be maintained.

Consistent with past Commission recommendations for site-neutral payments between HOPDs and freestanding physician offices, the Commission also supports expanding site-neutral payment rates to clinic visits provided in *on-campus* HOPDs so that it is the same as the payment rate for clinic visits provided in off-campus PBDs. The result would be that the payment rate for clinic visits provided in both off-campus and on-campus HOPDs would more closely match the rate paid under the Medicare PFS for office visits provided in physician offices.

The Commission acknowledges that there are different approaches to implementing site-neutral payments across ambulatory settings. In our June 2023 report to the Congress, we noted the benefits of making budget-neutral adjustments for some OPPS services in conjunction with site-neutral payments.[12] For example, applying a budget-neutral payment adjustment with a site-neutral policy would increase OPPS payment rates for other services including emergency department visits, which would support hospitals' emergency care and standby capacity.

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[11] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC, MedPAC.
[12] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC, MedPAC.

Proposed unbundling of skin substitutes and site-neutral payments

In this proposed rule, CMS reports a substantial increase in payments for skin-substitute products under FFS Medicare's ambulatory care payment systems, rising from $250 million in 2019 to $10 billion in 2024. CMS notes that there has not been significant growth in payments for skin substitutes under the OPPS, which unconditionally packages the payment for skin substitutes with the associated application procedures. Therefore, nearly all of this increased spending occurred under the Medicare PFS for skin substitutes furnished in nonfacility settings such as clinician offices.

Under the OPPS, Medicare's payment for skin substitutes that do not qualify for pass-through status are packaged into the payment for the associated service (treatment of a wound). CMS also uses this payment policy in the ASC payment system. By contrast, under the PFS, CMS has historically paid separately for most skin substitutes under Section 1847A of the Social Security Act based on each product's average sales price (ASP) plus 6 percent.[13] Under this method, each skin-substitute product receives a unique billing code and payment limit.

Beginning in 2026, CMS proposes a new system of paying for skin substitutes under the OPPS and PFS that is intended to slow the growth in FFS payments for these products while equalizing the payment rates for skin substitutes between the PFS and OPPS. Under this proposal, FFS Medicare would pay separately for the provision of skin-substitute products—excluding those that are approved by the Food and Drug Administration (FDA) under Section 351 of the Public Health Service (PHS) Act as biological products—as incident-to supplies when these products are used as part of a covered application procedure under the OPPS in the HOPD setting or under the PFS in the nonfacility setting.[14] Under both the OPPS and PFS, CMS would continue to pay for any skin-substitute products that are approved by the FDA as biological products based on each products' ASP plus 6 percent (per Section 1847A of the Act). For skin substitutes that are not approved by the FDA as biologicals, CMS proposes, beginning CY 2026, to:

- Classify each skin substitute into one of three payment categories based on each product's FDA regulatory pathway: (1) devices approved under FDA's premarket approval pathway; (2) devices cleared under FDA's 510(k) or De Novo process; and (3) products that are human cells, tissues, and cellular and tissue-based products (HCT/Ps) regulated under Section 361 of the PHS Act.
- Apply the same initial payment rate to all skin-substitute products across the three payment categories. The proposed payment rate would reflect the highest volume-weighted average payment of the three payment categories. CMS would calculate the initial payment using ASP pricing data and OPPS cost data weighted by OPPS volume.

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[13] If manufacturers do not report ASP data to CMS, then payment is based either on the wholesale acquisition cost (WAC) or invoices.
[14] Incident-to services and supplies are those provided as an integral, although incidental, part of the clinician's personal professional services during diagnosis and treatment.

- Establish a single payment rate of approximately $125.38/cm^2 (prior to the application of geographic adjustments) for all skin-substitute products. This payment rate reflects the volume-weighted payment of the 361 HCT/P payment group.
- Codify the definition of "biological" as "a product licensed under Section 351 of the PHS Act".
- Update the payment rate for the skin-substitute payment categories annually through the rulemaking process using each product's most recently available calendar quarter of ASP data, when available.[15]

Comment

The Commission applauds the agency's attention to the significant increase in Medicare program spending for skin-substitute products and strongly supports the changes the agency proposes to how Medicare pays for skin substitutes under the PFS. However, as CMS notes, the substantial growth in spending for skin substitutes has occurred almost entirely under the PFS. We have not seen evidence of a problem with how Medicare pays for skin substitutes under the OPPS. Indeed, in CMS's proposed rule for the CY 2026 PFS, the agency states that, "[n]otably, there has not been significant growth in payments for skin substitutes in the OPPS, which unconditionally packages the payment for skin-substitute products with their associated application procedures."[16] We concur.

Therefore, the Commission opposes CMS's proposed change to the OPPS. This proposal would change the OPPS payment status for most skin substitutes from packaged to separately payable. However, packaging is an essential component of the OPPS, as it encourages providers to use the most efficient delivery of care and fosters competition among similar items and services, which generates pressure on manufacturers and suppliers to reduce prices.[17] As the Commission has repeatedly said, paying separately under prospective payment systems such as the OPPS for items and services instead of packaging them in payment bundles would:

- undermine the integrity of the payment bundles;
- limit the competitive forces that generate price reductions among like services;
- possibly lead to overuse (to the extent clinically possible); and

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[15] In the event that ASP is not available for a particular product, CMS would use the hospital outpatient mean unit cost (MUC) data. If MUC is not available, CMS would use the product's wholesale acquisition cost (WAC). If WAC is not available, CMS would use 89.6 percent of the product's average wholesale price (AWP).
[16] Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2025. Medicare and Medicaid programs; CY 2026 payment policies under the physician fee schedule and other changes to Part B coverage and payment policies; Medicare Shared Savings Program requirements; and Medicare Prescription Drug Inflation Rebate Program. *Federal Register* 90, no. 134 (July 16): 32352–33261.
[17] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

- shift financial burden from providers to the Medicare program, beneficiaries, and taxpayers.[18]

The Commission therefore maintains that CMS should continue packaging skin substitutes with their associated procedures in the OPPS.

Comment solicitation on payment policy for software as a service

In this proposed rule, CMS identified several software-as-a-service (SaaS) technologies that have enough claims data for CMS to set OPPS payment rates in standard APCs for those items. However, CMS found that using those data to estimate costs for these SaaS items would result in payment rates for the SaaS items that would be substantially lower than what CMS said are manufacturers' purported costs.

Due to these discrepancies between the estimated costs from the claims data and the purported costs from manufacturers as well as a desire to develop payment policies that reflect the underlying value of SaaS technologies, CMS has requested public comment on SaaS payment issues in the OPPS.

Comment

The Commission has long maintained that the goal of Medicare payment is to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Regarding other new technologies such as drugs and biologicals, the Commission has said that Medicare should establish payment in a way that (1) promotes access to new technologies that meaningfully improve the diagnosis or treatment of beneficiaries, (2) ensures technologies' affordability for beneficiaries and taxpayers, and (3) creates incentives for the development of new technologies that lead to substantial clinical improvement.[19]

As noted above, for prospective payment systems (PPSs)—such as the OPPS—the Commission has repeatedly said that paying separately for items and services instead of packaging them in each sector's PPS payment bundles would:

- undermine the integrity of the payment bundles;
- limit the competitive forces that generate price reductions among like services;
- possibly lead to overuse (to the extent clinically possible); and

[18] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[19] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

- shift financial burden from providers to the Medicare program, beneficiaries, and taxpayers.[20]

Because of the potential problems that arise from paying separately for new technologies in lieu of larger payment bundles, the Commission encourages CMS to package ancillary items, such as SaaS technologies, into the payment bundles of the related primary services as long as beneficiaries' access is not adversely affected. For example, CMS had packaged several SaaS items, such as LiverMultiScan in 2022, before changing these items to separately payable in 2023. The Commission recognizes the need to ensure beneficiaries' access to new technologies that improve outcomes while preserving the incentives for efficiency that can be achieved in the OPPS through packaging. Combining a primary service with related ancillary items into a single payment unit encourages efficiency because the combination of inputs used to treat a beneficiary determines whether the provider experiences a financial gain or loss. Broader bundles also foster competition among similar items and services, which generates pressure on manufacturers and suppliers to reduce prices. The Commission has long supported larger payment bundles for the OPPS because they provide hospitals with opportunities to find flexibility in providing care and incentives to use the most cost-efficient methods. In addition, packaging SaaS items—relative to separate payment for specific SaaS items—creates more desirable incentives for providers because it encourages them to choose technologies based on what is most effective in their own operations and does not create or distort financial incentives for items that may not be efficacious or efficient.

In contrast, separate payment for SaaS items under the OPPS would leave Medicare with few pricing tools that would help the program strike a balance between maintaining incentives for innovation and ensuring affordability for beneficiaries and taxpayers. In addition, SaaS developers would face little competitive pressure when making pricing decisions, allowing them to set prices based on what they believe the U.S. health care market will bear for their products. Moreover, paying for SaaS items on a per use basis could lead to overuse of these technologies and could have significant fiscal implications for Medicare.

Proposed method to set IPPS relative weights using Medicare Advantage data

Under the IPPS, payments are required to be adjusted by diagnosis group relative weights that account for the relative hospital resources used. Relative weights that are too low or too high relative to costs are inequitable and create incentives for providers to expand service lines that are overpaid and reduce service lines that are underpaid.

[20] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

In 2005, MedPAC made several recommendations related to the IPPS, including that CMS refine the current diagnosis-related groups (DRGs) and calculate DRG relative weights using the estimated cost of providing care (rather than charges).[21]

In the FY 2008 final rule, CMS began implementing several refinements to IPPS diagnosis groups and relative weights, broadly consistent with MedPAC's recommendations.[22] This included moving to Medicare-severity diagnosis related groups (MS-DRGs) and basing their relative weights on the estimated costs of care.

Under the current process, MS-DRG weights are set using the estimated relative costs of different MS-DRGs based on departmental charges (from FFS claims data) converted to costs (using 19 departmental cost-to-charge ratios from hospital cost report data), and various standardizations and outlier trims.[23] For example, if hospitals' costs per discharge for patients with MS-DRG A are (on average) twice the costs for MS-DRG B, CMS will try to set the payment weight for MS-DRG A equal to twice the payment weight for MSDRG B. Moving to cost-based relative weights largely corrected the problem of some MS-DRGs being more profitable than other MS-DRGs.

In the CY 2020 OPPS final rule, CMS implemented hospital price transparency (HPT) requirements.[24]

In the FY 2021 IPPS final rule, CMS finalized a proposal to, starting with cost reports ending on or after January 1, 2021, require hospitals to use a subset of HPT data to report their median Medicare Advantage (MA) negotiated charge by MS-DRG, and starting FY 2024, to use this data to set "market-based" MS-DRG relative weights.[25] However, consistent with MedPAC's comment, CMS repealed these changes. [26]

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[21] Medicare Payment Advisory Commission. 2005. *Report to the Congress: Physician-owned specialty hospitals.* Washington, DC, MedPAC.
[22] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2007. Medicare program; changes to the hospital inpatient prospective payment systems and fiscal year 2008 rates. *Federal Register* 72, vol. 162 (August 22): 47129-48175.
[23] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Medicare and Medicaid programs and the Children's Health Insurance 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 2025 rates; quality programs requirements; and other policy changes. Federal Register 89, no. 167 (August 28): 68986-70046.
[24] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. Medicare and Medicaid programs: CY 2020 hospital outpatient PPS policy changes and payment rates and ambulatory surgical center payment system policy changes and payment rates. Price transparency requirements for hospitals to make standard charges public. *Federal Register* 84, no. 229 (November 27): 65524-65606.
[25] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and final policy changes and fiscal year 2021 rates; quality reporting and Medicare and Medicaid Promoting Interoperability Programs requirements for eligible hospitals and critical access hospitals. *Federal Register* 85, no. 182 (September 18): 58432-59107.
[26] Medicare Payment Advisory Commission. 2021. Comment letter on 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 Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program." June 23.

In this proposed rule, CMS reproposes a variant of the policies it finalized in FY 2021 and repealed in FY 2022. Specifically, CMS proposed to:

- Require IPPS hospitals to report median Medicare Advantage Organization (MAO) payment rate (defined as the "allowed amount" if based on an algorithm such as a percentage of FFS payment rates, or otherwise as the "negotiated charge") by MS-DRG on their Medicare cost reports ending on or after January 1, 2026; and
- Have CMS use this data to calculate MS-DRG relative weights to be used in IPPS payments beginning in FY 2029.

Comment

The Commission strongly supports efforts to improve data on the MA program and therefore broadly supports CMS's proposals to improve hospitals' price transparency reporting.

However, the Commission strongly disagrees with CMS's proposal to use MA rates to set MS-DRG relative weights.

As we noted in our comment letter to the FY 2021 IPPS proposed rule, using MA rates to set Medicare FFS MS-DRG relative weights would be largely circular as there is ample literature showing that MA plans generally set their rates for inpatient hospital services as a percentage of FFS Medicare payments. In addition, the proposed process would introduce distortions:

- In cases where MA plans pay hospitals for inpatient services as a percentage of FFS Medicare payments, MS-DRG relative weights would be distorted by existing FFS Medicare policy-based payments that do not correspond to the relative cost of providing the service. For example, FFS Medicare payments include uncompensated care payments to help support hospitals' costs of treating the uninsured. Another example is the numerous current wage index distortions discussed above. The proposed process would yield higher relative weights for MS-DRGs disproportionately performed at hospitals that receive these additional policy-based payments.
- In cases where MA plans pay hospitals for inpatient services based on charges, MS-DRG relative weights would be distorted by different cost-to-charge ratios across departments. The proposed process would yield higher relative weights for MS-DRGs that had higher mark ups of charges relative to costs to the extent some MA plans still pay hospitals a rate based on discounts off charges.

Centers for Medicare & Medicaid Services (2021). 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 2022 rates; quality programs and Medicare Promoting Interoperability Programs requirements for eligible hospitals and critical access hospitals; changes to Medicaid provider enrollment; and changes to the Medicare Shared Savings Program. *Federal Register* 86, no. 154 (August 13): 44774-45615.

The proposal could therefore decrease the accuracy of measuring the relative costliness of providing different inpatient services to Medicare beneficiaries, while increasing the burden on hospitals and CMS. The proposal may also provide hospitals incentives to alter their contracts with MA plans to influence MS–DRG relative weights (such as through negotiating higher reported prices for certain inpatient services, coupled with refunds outside of the reported price).

Before moving away from cost-based weights to weights based on prices paid by MA plans, CMS should first examine the price transparency data to see if the weights would be materially different and if so, if the cause is the potential distortions listed above. Only then should CMS consider whether there are any scenarios, such as low-volume MS–DRGs, for which adding MA data would improve the accuracy of measuring the relative costliness of providing different inpatient services to Medicare beneficiaries.

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 contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair