MEDPAC | Medicare Payment Advisory Commission

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

Amol S. Navathe, M.D., Ph.D., Chair
Gregory P. Poulsen, M.B.A., Vice Chair
Paul B. Masi, M.P.P., Executive Director

June 9, 2026

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

Attention: CMS-1849-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 2027 Rates; Requirements for Quality Programs; and Other Policy Changes," *Federal Register* 91, no. 71, pp. 19312–19887 (April 14, 2026). 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:

- implement the Comprehensive Care for Joint Replacement Expanded model; and
- repeal the alternative pathways for the inpatient prospective payment system's (IPPS's) new technology add-on payments (NTAPs) and for the outpatient prospective payment system's (OPPS's) pass-through payments.

Proposed implementation of the Comprehensive Care for Joint Replacement Expanded model

For fiscal year (FY) 2027, CMS proposes a nationwide, mandatory episode-based payment model for certain surgical procedures. The Comprehensive Care for Joint Replacement Expanded (CJR-X) model builds on the earlier Comprehensive Care for Joint Replacement (CJR) model, which was tested in 34 regions from 2016 to 2024. Under CJR-X, participating hospitals would be responsible for total Part A and Part B fee-for-service (FFS) Medicare spending and quality performance during a 90-day episode that includes and follows hip, knee, or ankle replacement surgeries.

All providers caring for patients assigned to the model would continue to be paid under existing FFS payment systems. Total Medicare FFS spending during a 90-day episode would then be compared with an episode target price. If spending fell below the target, the hospital would receive a bonus equal to the difference between actual spending and the target; if spending exceeded the target, the hospital would be required to repay Medicare the difference. (Bonuses and repayments for each episode would generally be capped at 20 percent of the target price.)

The proposed calculation of CJR-X episode target prices differs from the method that has been used in some other episode-based payment models, wherein target prices were based entirely or partly on hospital-specific spending. CMS proposes to base CJR-X episode target prices entirely on spending within the region where the hospital is located, using regional spending from the most recent three-year period, trended forward to the current year based on regional spending trends. These amounts would then be risk-adjusted to reflect beneficiary- and hospital-level risk factors. A normalization factor (subject to limits) would be used to adjust target prices and would constrain increases in program spending due to growth in risk scores. A hospital-specific discount factor would also be applied, in the form of a percentage reduction from the expected spending amount for each episode; this discount factor is designed to produce savings for the Medicare program. CMS proposes a standard discount factor of 2 percent, which would be reduced for hospitals with high quality scores.[1] Each year, target prices would be updated to reflect changes in actual spending within the region and changes in a CJR-X participant's quality performance.

Most acute care hospitals paid under Medicare's IPPS would be required to participate in CJR-X. Low-volume hospitals and hospitals located in regions where the Transforming Episode Accountability Model (TEAM) is in effect would be exempt. However, beneficiaries could simultaneously be assigned to a CJR-X episode and an accountable care organization (ACO) model, such as the Medicare Shared Savings Program. In cases of such overlap, CMS proposes to attribute the total FFS spending during an episode to both the CJR-X hospital and the ACO. In contrast, model payments paid to CJR-X participants (or model penalties incurred by them) would not be counted as spending attributed to the ACO, and vice versa.

Comment

We support CMS's proposed CJR-X model. The proposed design is consistent with the Commission's June 2021 recommendation that CMS streamline and harmonize its

[1] A CJR-X participant's composite quality score would be based on how their performance on five quality measures compares to hospitals nationally (since these five measures are already reported by hospitals). The five measures are: hospital-level risk-standardized complication rate following elective primary total hip and/or knee arthroplasty (joint replacement surgery); hospital visits within 7 days of hospital outpatient department surgery; inpatient patient experience survey (HCAHPS); outpatient and ambulatory surgery patient experience survey (OAS CAHPS); and hospital-level total hip and/or knee arthroplasty patient-reported outcome-based performance measure. The maximum quality score CJR-X participants could earn would be 20 points. Participants with a score of at least 17.1 out of 20 would have a 0 percent discount factor applied to their episode target price; participants with a score of 12.1 to 17.0 would have a 1 percent discount factor applied; participants with a score of 6.1 to 12.0 would have the full 2 percent discount factor applied; and participants with a score of 6.0 or lower would not be eligible to receive a reconciliation payment from CMS.

portfolio of advanced alternative payment models (A–APMs), instead of operating a series of A–APMs that are effectively developed independent of one another.[2] The Commission has also supported Medicare implementing a national, episode-based payment model that would be mandatory for certain providers and certain proven clinical episodes (e.g., hip and knee replacements), even if a beneficiary were concurrently attributed to an ACO.[3] The proposed CJR-X model largely conforms to that approach.

If CMS implements the proposed model, it will be important for the agency to monitor the financial effects of the model's overlap policy, which would result in two different A–APMs (CJR-X plus some other A–APM, such as an ACO model) holding two sets of providers accountable for spending for a single beneficiary during a single, shared period of time (i.e., a 90-day episode in CJR-X, which could also end up being included in the 12-month performance period of another A–APM). We noted in our June 2022 report that when implementing new model overlap policies, performance payments for providers should not be so large that they increase total Medicare spending. If the CJR-X overlap policy results in net increases in Medicare spending, CMS should consider changing the policy.

In addition, we note that under CJR-X, episode target prices would be based entirely on spending within the region where the hospital is located (rather than based, at least in part, on a participating hospital's own prior spending) and be rebased each year to reflect multi-year changes in episode spending at the regional level. Basing episode target prices entirely on regional spending means that upon launch of the model, hospitals with historical episode spending that is less than the regional average could initially receive large positive bonus payments, while hospitals with historical episode spending above the regional average could face significant repayment requirements. One way to address this issue would be to initially base benchmarks on a blend of hospital-specific and regional spending and each year increase the share of the blend based on regional spending. Some observers, including the Commission, have also expressed concerns about using actual spending at the hospital level to rebase spending targets because doing so can make it increasingly difficult for high-performing hospitals to maintain future spending levels below the targets. Rebasing target prices using regional rather than hospital-specific spending should help mitigate concerns about this issue.

Since the method of calculating episode target prices is critically important in determining whether the model achieves net savings, CMS should closely monitor the effects of its approach for rebasing target prices in CJR-X and modify it if needed.

---

[2] Medicare Payment Advisory Commission. 2021. "Chapter 2: Streamlining CMS'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/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch2_medpac_report_to_congress_sec.pdf

[3] Medicare Payment Advisory Commission. 2022. "Chapter 1: 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

Proposed repeal of the alternative pathways for IPPS new technology add-on payments and OPPS pass-through payments

CMS proposes to repeal parts of regulations affecting when certain new drugs and devices are eligible to receive temporary additional payments from the Medicare program. The two alternative pathways that CMS proposes to repeal effective 2028 are:

- *Alternative pathways for NTAP payments under the IPPS*. Starting in FY 2021 or 2022, certain technologies—transformative new devices designated by the FDA as Breakthrough Devices; antimicrobial products designed by the FDA as a Qualified Infectious Disease Product (QIDP); or products approved under the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD)—may qualify for additional payments under alternative pathways that do not require that the technology represent a substantial clinical improvement.

- *An alternative pathway for transitional pass-through payments under the OPPS*. Starting in calendar year (CY) 2020, certain devices—those designated by the FDA as Breakthrough Devices—may qualify for additional payments under an alternative pathway that does not require that the device represent a substantial clinical improvement.

The repeal of these alternative pathways would result in all IPPS NTAP and OPPS pass-through applicants for 2028 and beyond needing to meet the standard eligibility criteria, including the substantial clinical improvement requirement.[4] The agency believes that doing so would better align spending and value and would support providers in delivering data-driven care:

> "By requiring all technologies to demonstrate that they offer a substantial clinical improvement as part of our evaluation process, we believe we will be better able to make evidence-based decisions on which technologies should receive these additional payments. We believe that holding all applicants to the same standards and requiring all applicants to demonstrate that their technologies meet the same criteria maintains our focus on new and innovative technologies that improve beneficiary health outcomes while strengthening the evidence base supporting our approval decisions for new technology add-on payment and OPPS device pass-through payment, ensuring value for American taxpayers and Medicare beneficiaries."

[4] The standard eligibility criteria for IPPS NTAPs are: (1) the medical service or technology must be new; (2) the medical service or technology must be costly such that the diagnosis-related group (DRG) rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. The standard eligibility criteria for OPPS device pass-through payments are: (1) the device must be new, (2) the device must not be described by an existing device category; and (3) the cost of the device must be significant. For more details see 42 CFR 412.87(b) and 419.66.

Comment

The Commission supports CMS's proposal to repeal the alternative pathways for IPPS new technology add-on payments and OPPS pass-through payments and thus require that all technologies receiving these additional payments meet the substantial clinical improvement requirement. The Commission recognizes the need to maintain financial rewards for innovation while preserving the incentives within the IPPS and OPPS for efficiency. Including the substantial clinical improvement requirement ensures that additional Medicare payments are used to support Medicare beneficiaries' access to innovations that are demonstrated to improve outcomes compared to the currently available treatment.

CMS's proposal is consistent with the Commission's comment letter on the IPPS proposed rule for FY 2020, in which we indicated our lack of support for the use of the FDA's Breakthrough Device Program for qualification for NTAP unless the drug or device in question also meets the current substantial clinical improvement criterion—that is, unless there is some evidence that the new technology results in improved care for beneficiaries. In that letter, we stated that, "The Commission maintains that the Medicare program, not the FDA, should adjudicate spending determinations based on the specific needs of the Medicare population."[5] We also noted that:

> "The Commission has long held that Medicare should pay similar rates for similar care. To protect the well-being of beneficiaries and ensure good value for the Medicare program and thus the taxpayers, Medicare should not pay more for technologies that have not yet been proven to provide better outcomes for beneficiaries. Therefore, drugs or devices should not qualify for NTAP if there is no evidence that the drug or device is an improvement relative to existing care."[6]

Likewise, in the Commission's comment letter on the OPPS proposed rule for CY 2020, we did not support CMS's proposal to use the FDA's Breakthrough Device Program for qualification for pass-through payment unless the device in question also meets the substantial clinical improvement requirement.[7] And in the Commission's comment letter on the IPPS proposed rule for FY 2021, we did not support the use of the FDA's LPAD for qualification for NTAP unless the drug in question also meets the current substantial clinical improvement requirement.[8]

The Commission has also supported a clinical superiority requirement being included in two other contexts:

---

[5] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/06212019_medpac_2020_ipps_ltch_comment_v3_sec.pdf.
[6] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/06212019_medpac_2020_ipps_ltch_comment_v3_sec.pdf.
[7] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09132019_opps_asc_2020_medpac_comment_v2_sec.pdf.
[8] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/07072020_fy2021_ipps_medpac_comment_v2_sec.pdf.

- In our June 2021 report to the Congress, we recommended that the Secretary modify the pass-through drug policy in the OPPS so that it includes only drugs and biologics that function as supplies to a service and applies only to drugs and biologics that are clinically superior to their packaged analogs.[9] We cautioned that "[w]ithout a clinical superiority requirement, Medicare could pay separately for a drug no more effective than a competing drug already in use, even when the cost of the existing drug is reflected in the OPPS payment rate for the applicable service."[10]

- In our comment letters on the end-stage renal disease (ESRD) prospective payment system (PPS) proposed rules for CY 2025 and CY 2022, we stated that CMS should use a clinical superiority requirement if the agency continues the ESRD PPS's transitional drug add-on payment adjustment (TDAPA) policy and post-TDAPA for ESRD drugs in an existing ESRD functional category.[11]

We note that the Commission continues to have general concerns about how Medicare pays for new costly technology, including drugs and biologicals. In our comment letter on the IPPS proposed rule for FY 2022, we said that cost criteria used to determine payment for new technology provides an incentive for manufacturers and hospitals to increase their prices and charges.[12]

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,

Amol S. Navathe, M.D., Ph.D.
Chair

---

[9] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch8_medpac_report_to_congress_sec.pdf.
[10] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch8_medpac_report_to_congress_sec.pdf.
[11] https://www.medpac.gov/wp-content/uploads/2025/08/08292025_MedPAC_CY2026_ESRD_COMMENT_v2_SEC.pdf and https://www.medpac.gov/wpcontent/uploads/2022/08/08192022_ESRD_CY2023_MedPAC_COMMENT_SEC.pdf.
[12] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/06252021_fy_2022_ipps_ltch_medpac_comment_sec.pdf.