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September 15, 2025

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

Re: [CMS-1834-P] 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; *July 17, 2025.*

Dear Administrator Oz:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed CY 2026 rule related to the Medicare Program Hospital Outpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, general medical surgical hospitals and large academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

CMS's Proposed Payment Update is Inadequate Given Continued Inflation and Other Cost Increases

In this rule, CMS proposes a net increase of 2.4% for CY 2026. This update continues CMS's recent trend of payment policies that do not acknowledge the true level of inflation and cost increases impacting health care and the country as a whole. It fails to account for the persistent labor, supply and drug costs the hospital field has experienced in the last three years and continues to face. ***Given such cost increases caused by inflation over the last few years, the market basket is inadequate, particularly when taken together with the insufficient increases that greatly lagged true inflation in the last few years.***

An April 2025 report by the American Hospital Association highlights some of the cost increases hospitals are bearing right now:

- Overall inflation grew by 14.1% from 2022 through 2024 — nearly 3 times as fast as Medicare reimbursement for hospital inpatient care, which increased by 5.1% during the same time.
- Medicare Advantage is having a growing deleterious impact on hospitals, with MA plans lengthening observation stays to around 37% longer than in traditional Medicare.
- Meanwhile, MA payments fell by nearly 9% on a cost basis from 2019 to 2024, as plans negotiate rates below the traditional Medicare DRG payment.

Wisconsin has seen these same challenges: costs for supplies and services, which are largely outside of hospitals' control, increased by 16.6% from 2021 to 2023 in Wisconsin. Meanwhile, salary/fringe costs

increased 11.3% over the same time period. With this imbalance between the increases in expenses and revenues, it's no surprise that hospitals are facing some of the hardest financial times in recent memory. According to data from WHA's most recent fiscal survey, in 2023, nearly one-third of Wisconsin hospitals operated with a negative margin.

The underpayments from Medicare have been driving these recent challenges. In Wisconsin, hospitals are paid only about 74% of what it costs to provide care to Medicare patients according to that same fiscal survey. And because Wisconsin is an aging state, it is seeing a large shift in people moving off private insurance and onto Medicare. From 2016 to 2023, the average payor mix for a Wisconsin hospital has seen Medicare grow from 45% to 49%, while commercially insured patients have shrunk from 37% of the payor mix to only 32% concurrently, according to claims data analyzed by WHA's Information Center. In fact, as of 2024, Wisconsin was tied for 8th among states with the highest percentage of their population covered by Medicare, at 21%. Due to this, **annual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.3 billion in 2023, an 86% increase.** This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age.

Hospitals are increasingly under reimbursed for long patient stays and post-acute care they are providing. The average length of a patient stay increased 9.9% by the end of 2021 compared to pre-pandemic levels in 2019, leading hospitals to devote more staff time and expenses per patient episode. On top of this, according to a Baker Tilly report commissioned by the Wisconsin Department of Health Services, Wisconsin hospitals lost an estimated $465 million in uncompensated care from patients they have not been able to discharge due to the lack of available nursing home beds – patients hospitals are not receiving reimbursement for after their hospital care concludes.

With these historic fiscal challenges facing hospitals, **we urge CMS to focus on appropriately accounting for recent and future trends in inflationary pressures and cost increases in the hospital payment update, which is essential to ensure that Medicare payments for acute care services more accurately reflect the cost of providing hospital care.**

CMS Should Not Move Forward with an Accelerated 340B Claw Back or 340B Drug Acquisition Cost Survey

In this rule, CMS announces it is considering expediting its recoupment of hospital payments that went out due to the previously ruled unlawful 340B cuts being applied in a budget neutral manner. The agency had previously finalized a recoupment strategy recouping the full $7.8B in payments from 2026-2042; the new timeline would fully recoup these payments by 2031, or even as early as 2028.

WHA opposes CMS moving forward with this change in repayment strategy, especially since CMS has already taken public comment on and finalized their previous proposal to spread the recoupment across a much longer time-period. The longer glide-path minimizes the impact on hospitals that are already plagued with Medicare payment rates that are not keeping up with the true cost of inflation. Hospitals must plan out their budgets based on expectations around existing payment guidelines and often must consider future plans for opening new facilities, purchasing new medical equipment, raising pay rates to recruit and retain staff, and expanding in-demand service lines like OB and behavioral health that often lose hospitals money.

It's worth noting that CMS was ordered by the United States Supreme Court in a unanimous decision to repay 340B hospitals due to its own illegal actions to reduce payments to 340B hospitals in the first place. As WHA has previously argued, CMS should not be asking hospitals to bail it out for its own unlawful actions, and it is dubious as to whether CMS even has the authority to retroactively apply budget neutrality requirements in this manner.

WHA is also very concerned about CMS's proposal to inflict unnecessary costs on hospitals with a new drug acquisition cost survey of all hospitals paid under the OPPS. The Government Accountability Office itself said in

a 2006 report that cost surveys "created a considerable burden for hospitals." Hospitals are already devoting significant resources toward 340B compliance due to actions by drug companies and existing program integrity requirements.

Additionally, it's worth understanding why CMS is proposing this in the first place: because after being soundly defeated by the U.S. Supreme Court, it is pursuing the same policy to cut reimbursements to 340B hospitals in a way that undermines the intent of the 340B Prescription Drug Discount program. According to Congressional Report language, and as HRSA notes on its website, "the **340B Program enables covered entities to stretch scarce federal resources** as far as possible, reaching more eligible patients and providing more comprehensive services." How can hospitals stretch scarce resources if the federal government, which already reimburses Wisconsin hospitals only about 74% of what it costs them to provide care to Medicare patients, is using this provision to further erode 340B hospital financial resources?

Removal of Hospital Inpatient-Only List

WHA is concerned about CMS's proposal to phase out the 1,731 procedures on the inpatient-only (IPO) list over a 3-year period. While WHA generally supports proposals to remove unnecessary regulations, we are concerned about the potential unintended effects such a drastic change could have on the quality of care. The IPO was created to protect patients and many of its services are complicated, invasive surgeries that have historically involved a multiple-day hospital stay due to potential complications such as infections. They also may require significant rehabilitation and recovery periods that benefit from careful coordination of care in the inpatient hospital setting. Removing these patient protections over such a quick time period could put patients at risk and place further strain on hospitals that inevitably will care for the patients when complications arise that the outpatient setting is not equipped to care for.

This could also have implications for Medicare's post-acute care benefits. For instance, WHA has long been a proponent of eliminating the nursing home 3-day stay requirement which requires 3 consecutive days of inpatient hospital care before Medicare will reimburse for nursing home care. However, as long as this policy persists, if the IPO ends, without a three-day inpatient hospital stay, Medicare beneficiaries who would have previously qualified for Medicare-covered skilled-nursing facility care would no longer qualify.

CMS Should not Move Forward with Site-Neutral Payments

WHA opposes the proposal to begin paying previously grandfathered off-campus hospital outpatient departments at the "site-neutral" physician clinic rate for drug administration services. Moving forward with this proposal would lead to an estimated $7 million cut to Wisconsin hospitals in 2026, or around $90 million over the next 10 years. WHA also strongly opposes further extending site-neutral payment policies, such as CMS's request for information on whether it should pursue site-neutral payments at *on-campus* hospital outpatient departments.

As previously noted, it is a well-known fact that *Medicare already underpays hospitals.* Based on WHA analysis of required annual hospital reports, Wisconsin hospitals are paid about 74% of what it costs them to care for Medicare patients, contributing to annual underpayments exceeding $3.3 billion.

This proposal fails to recognize that long-standing Medicare payment policy was designed to pay higher rates at hospital outpatient departments (HOPDs) because they are an extension of hospitals that have been shown to treat sicker, more vulnerable patients. The higher payments also recognize that the hospitals they support:

- Provide emergency room and inpatient (and often intensive care unit) care 24/7/365.
- Provide more specialized care for patients with higher acuity needs.
- Serve patients regardless of their ability to pay, including a higher mix of Medicaid/Medicare patients.

CMS has also previously recognized that Medicare payment rates reflect the higher costs associated with delivering services in an HOPD:

"When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively."[i]

It is also concerning that CMS is citing authority for these cuts, "to control unnecessary increases in the Volume of outpatient services," that appears to be in direct conflict with the Bipartisan Budget Act of 2015 and 21st Century Cures Act, which intentionally grandfathered existing on-campus and off-campus HOPDs at the current higher payment rate. While CMS prevailed against a court challenge to prior usage of this authority, the case was decided in CMS's favor only after an appeals court cited the Chevron doctrine of agency deference that has now been called into question as a result of the 2024 Loper Bright decision.

Hospital Quality Star Rating Request for Information (RFI)

The Overall Hospital Quality Star Rating assigns hospitals a rating from one to five stars based on publicly reported hospital performance on quality measures in five categories: Safety, Mortality, Readmissions, Patient Experience, and Timely & Effective Care. In response to CMS's Request for Information (RFI) issued last year regarding the Hospital Quality Star Ratings methodology, Wisconsin hospitals welcomed the opportunity to engage in a thoughtful dialogue about how best to reflect hospital performance in a way that is both meaningful to patients and fair to providers. That RFI acknowledged longstanding concerns about the accuracy and transparency of the ratings system (particularly, the role of the Safety of Care domain) and invited stakeholders to weigh in on potential reforms.

As representatives of Wisconsin's hospital community, we appreciate CMS's continued commitment to improving transparency and patient safety through the Hospital Star Ratings system. However, we have significant concerns about the proposed changes to the Safety of Care domain and their disproportionate impact on hospitals across our state; particularly those serving rural and underserved populations.

Wisconsin hospitals have long prioritized quality improvement, and many have made measurable progress in patient experience, readmission rates, and timely care. The proposed reweighting of the Safety of Care domain from 16% to 22%, coupled with punitive measures for hospitals in the lowest quartile, introduces a rigid structure that may not fully account for the resource constraints and patient complexity faced by smaller facilities. Capping high-performing hospitals at four stars in 2026 and reducing them by a full star in 2027 based solely on safety quartile ranking risks undermining public trust and misrepresenting the overall quality of care provided.

WHA supports CMS's goal of elevating the importance of patient safety and agrees that weighting the Safety of Care domain equally with other domains is a meaningful and appropriate step forward. However, WHA urges CMS to adopt a more incremental approach. Specifically, we recommend implementing the reweighting first and allowing hospitals time to respond and improve without immediately imposing the additional punitive steps of capping ratings in 2026 or applying a one-star blanket reduction in 2027. This phased strategy would promote accountability while preserving fairness and encouraging continuous improvement.

Many Wisconsin hospitals serve aging populations, patients with chronic conditions, and communities with limited access to post-acute care. Penalizing these institutions without contextualizing their challenges may lead to reduced patient volume, disparities in access and perception, and difficulty recruiting clinical talent; all of which could further compromise safety outcomes.

We urge CMS to consider an approach that supports improvement without imposing blanket penalties. Incorporating risk adjustment, stratified reporting, and technical assistance for hospitals in the lowest quartile would better align with the goals of equity and continuous quality improvement. Wisconsin hospitals remain committed to advancing safety, but we ask that CMS recognize the complexity of our care environments and partner with us in a way that promotes progress.

Hospital Price Transparency

While WHA supports the goal of enhancing hospital price transparency, we are concerned with newly proposed requirements for hospitals to calculate and report the 10th percentile, median, and 90th percentile allowed.

With the existing hospital price transparency data, third-party groups already aggregate and analyze hospital machine-readable files (MRFs) to provide comparative pricing insights, demonstrating that MRF data can be used to generate percentile-based analytics, particularly for high-volume services and standardized payer arrangements. WHA believes that hospitals have already fulfilled their obligation by making pricing data publicly available in the required format and opposes heaping additional regulations onto hospitals.

CMS Should Not Move Forward with Its Proposal to Use MAO Median Rates to Calculate FFS Rates

In this rule, CMS proposes to require hospitals to include on the annual Medicare cost report what the agency calls "market-based payment rate information."[ii] Specifically, hospitals would be required to report on the Medicare cost report, beginning January 1, 2026, the median of the payer-specific negotiated charges, by MS-DRG, that the hospital has negotiated with all of its Medicare Advantage Organizations (MAOs).[iii] The agency also proposes using the median payer-specific negotiated charges as reported on the Medicare cost report to calculate IPPS MS–DRG relative weights beginning in FY 2029.[iv]

CMS adopted two similar policies in its FY 2021 Inpatient Prospective Payment System (IPPS) final rule, only to repeal both policies one year later. In its FY 2022 IPPS final rule, CMS repealed both the collection of market-based rate information on the Medicare cost report, effective for cost reporting periods on or after January 1, 2021, and the market-based MS–DRG relative weight methodology effective in FY 2024.[v]

<u>WHA continues to oppose CMS' proposal to require hospitals to calculate and report on the Medicare cost report the median of charges negotiated with all of its MAOs for use by CMS in calculating Medicare IPPS MS–DRG relative weights effective FY 2029</u>.

As WHA noted in our comments when CMS first proposed these two policies in its FY 2021 IPPS proposed rule, CMS's use of median payer-specific negotiated charge information by MS-DRG to change relative weights would be arbitrary and capricious. As set forth in section 1886(d)(4)(B) of the Act, relative inpatient DRG weights are intended to reflect "the relative hospital resources used with respect to discharges classified within that group" and not the relative price paid. Further, as required under 42 CFR § 412.60(b), "CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used." In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than costs is a better measure of hospital resources used. Instead, the agency appears to *conflate market price with cost*.

The rationales CMS uses for basing MS-DRG relative weights on price have nothing to do with whether median payer-specific negotiated charges are a measure of "hospital resources used" as the Medicare statute requires. Rather, CMS proposes to use this information to "to develop market-based approaches to payment under the Medicare FFS system."[vi] But that is not the statutory test. Simply put, we believe CMS has not adequately explained why basing IPPS MS-DRG relative weights on market price would result in relative weights being based on hospital resources used. As such, it would be arbitrary and capricious to adopt this proposal. *See Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29 (1983).

WHA appreciates the opportunity to provide comments on this proposed rule.

Sincerely,

Kyle O'Brien
President & CEO

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[i] CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.
[ii] 90 Fed. Reg. 33481 (July 17, 2025).
[iii] 90 Fed. Reg. 33304 (July 17, 2025).
[iv] Id., at 3805.
[v] 86 Fed. Reg. 45319 (August 13, 2021)
[vi] 90 Fed. Reg. 33481 (July 17, 2025).