4040 Wilson Blvd.
Suite 300
Arlington, VA 22203

info@idsociety.org
703.299.0200
IDSOCIETY.ORG

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Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: 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

Dear Administrator Oz,

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System Proposed Rule. IDSA is a global community of 13,000-plus clinicians, scientists and public health experts working together to solve humanity's smallest and greatest challenges, from tiny microbes to major outbreaks. Infectious diseases remain among the most pressing challenges facing health care systems, frequently causing and complicating chronic disease in patients of all ages. ID physician care has been proven to improve patient outcomes, reduce hospital length of stay and reduce costs.

We are pleased to support several components of the CY 2026 OPPS and ASC Proposed Rule as well as offer suggestions to strengthen some provisions, as detailed below.

OPPS conversion factor update

IDSA supports the proposal to update the CY 2026 Hospital Outpatient Prospective Payment System conversion factor to $89.958, representing an overall increase of 2.4% before budget neutrality adjustments. We recognize that this increase, grounded in the proposed hospital inpatient market basket update of 3.2% less the productivity adjustment of 0.8%, appropriately reflects rising input costs and ensures that OPPS payments keep pace with inflation and the evolving demands of providing hospital outpatient services. Continued, predictable annual updates to the conversion factor are essential for hospitals and affiliated specialized outpatient departments, including those providing complex infectious diseases management and infusion services, to maintain workforce stability, clinical infrastructure and uninterrupted patient care.

However, we flag for CMS' awareness that the hospital community continues to express concern that the proposed hospital market basket update may not adequately capture the full extent of rising costs for hospitals. Notably, stakeholders such as the American Hospital Association have publicly emphasized ongoing inflationary pressures, workforce challenges and

increasing supply expenses that may not be fully reflected in the proposed update, and that these gaps could affect hospitals' ability to sustain critical outpatient services.

OPPS payment proposals

Site neutrality payment policy for drug administration

CMS has proposed to expand site-neutral payment policies for drug administration services furnished in off-campus provider-based departments (PBDs). IDSA recognizes CMS' statutory authority to align payments for non-grandfathered off-campus PBD services with the Medicare Physician Fee Schedule (MPFS) to help control unnecessary increases in volume and spending. However, this new proposal would extend this lower payment rate, 40% of the standard OPPS rate for services assigned to drug administration ambulatory payment classifications (APCs 5691, 5692, 5693 and 5694), to "grandfathered" (excepted) off-campus PBDs as well.

While IDSA supports efforts to target inappropriate incentives and ensure value, we believe it is critical that payment policy recognizes the increased complexity and resource requirements involved in safely managing complex and high-acuity infusions in the outpatient setting. Rather than aligning incentives to favor hospital admission, payment rates should reflect and support the actual costs and expertise needed for the outpatient management of these therapies, particularly for conditions commonly overseen by infectious diseases specialists. Lowering payment for these vital outpatient services may inadvertently encourage shifting care back toward hospital admission, contrary to the goals of value-based care, patient preference and overall cost containment.

Many infectious diseases therapies, including prolonged outpatient parenteral antimicrobial therapy (OPAT), complex immunotherapy and management of multidrug-resistant infections, are often best delivered in hospital-affiliated outpatient infusion centers, where specialized clinical oversight, infection prevention and emergency support are readily available. A payment reduction across all off-campus PBDs could jeopardize the financial viability of these vital infusion services, particularly in rural or underserved areas already facing workforce shortages. Furthermore, hospital-based infusion centers may serve a higher proportion of clinically complex, immunocompromised or high-risk patients who may not be safely or appropriately managed in lower-acuity office settings.

IDSA urges CMS to instead consider increasing payment rates for complex outpatient management to accurately reflect the clinical and operational resources required, ensuring the financial sustainability and accessibility of these essential services outside the hospital. As CMS moves forward, it is important to recognize the risks of incentivizing inpatient over outpatient care for these populations due to unfavorable outpatient reimbursement. **We urge CMS to carefully monitor the impact of this site-neutral payment policy on patient access to necessary infusion services and to consider flexibilities or exemptions, such as for high-risk infusions, post-acute infectious disease management or patient populations with limited treatment alternatives, to preserve continuity and quality of care.**

Virtual direct supervision of diagnostic services furnished to hospital outpatients

IDSA supports the proposal to make the availability of direct supervision for diagnostic services via real-time audio-video communications technology (excluding audio-only) permanent, with the exception of services that have a 010 or 090 global surgery indicator. This policy, first adopted as a temporary flexibility during the COVID-19 public health emergency and subsequently extended, has proven to enhance patient access and workforce efficiency without compromising care quality for lower-risk diagnostic services. By formalizing this approach, CMS rightly recognizes advances in telehealth and the routine ability of supervising practitioners to be "immediately available," supporting modern and flexible care delivery models, an essential consideration for the ID specialty, which frequently provides expertise across multiple sites of care. Excluding

higher-risk procedures requiring more intensive oversight is an appropriate safeguard. IDSA believes this change will maintain patient safety while expanding the availability of infectious diseases consultation and diagnostic oversight, particularly in resource-limited or rural areas where on-site physician presence may be impractical. **We urge CMS to finalize this proposal and continue to monitor its impact to ensure it supports high-quality, safe and accessible diagnostic care for all beneficiaries.**

Changes to the Hospital Price Transparency Program

CMS proposes new requirements for reporting the "median allowed amount" as well as the 10th and 90th percentiles of allowed amounts, an updated accuracy attestation statement, the mandatory inclusion of hospital National Provider Identifiers (NPIs) and a voluntary hearing waiver for reduced civil monetary penalties (CMPs). These proposals represent significant steps toward modernizing the program, standardizing public data and supporting efforts to foster informed health care decision-making.

IDSA supports CMS' proposals to require hospitals to include the median, 10th percentile, and 90th percentile allowed amounts received from third-party payers for each item or service. These additional data elements will offer a more robust and nuanced picture of negotiated rates across payers and patient populations, enabling patients, clinicians and referring providers to better assess price variation and outlier charges for essential services, including those frequently used in infectious diseases care, such as infusions, diagnostics and infection control procedures. Improving clarity and comparability of hospital pricing is especially salient where costly, resource-intensive therapies or services are at stake, and may help drive value-based decision-making and reduce financial uncertainty for patients with complex infectious diseases.

IDSA also endorses the proposed updates to the required accuracy attestation statement, which strengthen hospital accountability by making it clear that posted data must be, to the best of the institution's knowledge, truthful, accurate and complete as of the posting date. The requirement to encode the name of the hospital's chief executive officer, president or senior official responsible for data reporting further underlines this commitment to data integrity. IDSA believes that these changes will increase the reliability of price transparency resources available to both patients and referring clinicians, which is essential for shared clinical decision-making and for maintaining public trust in the transparency process.

Requiring the inclusion of hospital NPIs in the machine-readable file will improve the usability of posted data by payers, researchers and referring clinicians. For infectious diseases physicians who routinely coordinate care across multiple hospital systems, the ability to accurately distinguish service locations and associated price data is crucial for steering patients toward high-value care settings and helping patients navigate complex coverage and billing scenarios.

Additionally, the inclusion of hospital NPIs would significantly improve ID attribution. Accurate NPI data enables both payers and clinicians to track which hospitals are responsible for the provision of ID services, supporting more precise measurement and reporting for quality improvement, reimbursement and outcomes analysis. This granularity helps ensure that infectious diseases care can be recognized and evaluated correctly, facilitating identification of patterns, gaps and opportunities for improvement within and across hospital systems. By strengthening ID attribution, NPIs can help support policy initiatives aimed at optimizing infectious diseases management, antimicrobial stewardship and coordinated care, ultimately benefiting patients, hospitals and the broader health care system.

Finally, IDSA generally supports the proposal to offer hospitals the option to waive their right to a hearing in exchange for a reduction in assessed CMPs for price transparency violations, as this may provide an incentive for more rapid resolution of compliance issues and prioritize timely corrective action over protracted litigation. However, we would encourage CMS to ensure that this option is exercised only with full understanding and voluntary consent from hospitals, and recommend clear public communication

about the resolution of such cases to maintain the credibility and enforcement strength of the Price Transparency Program.

OPPS Quality Proposals

Changes to the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) program measure sets

IDSA strongly opposes the proposal to remove the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure from the OQR and ASCQR program measure sets beginning with the CY 2024 reporting period. This quality measure has been essential for tracking and incentivizing vaccination uptake among front-line health care workers, a cornerstone of infection prevention and safeguarding patient safety in health care environments. Despite a decline in overall COVID-19 mortality, the ongoing circulation of SARS-CoV-2, together with the emergence of new variants and the ongoing vulnerability of immunocompromised and high-risk patient populations, demands continued vigilance. Removal of this measure would hinder transparency, impede benchmarking efforts and undermine sustained accountability for hospitals and ASCs to maintain strong vaccination coverage among staff. Retaining this measure affirms CMS' and the broader public health community's commitment to science-based, evidence-driven safety practices that remain necessary for protecting both patients and the clinical workforce.

Additionally, IDSA urges CMS to consider the importance of influenza vaccination coverage among health care personnel as a foundational example of infection prevention, with longstanding evidence that immunizing health care workers against influenza helps protect both patients and staff. Though influenza vaccination is not currently included as a required OQR/ASCQR metric, IDSA believes that continued attention to immunization, especially for highly transmissible respiratory pathogens, is crucial and recommends CMS look for opportunities to strengthen hospital reporting and staff vaccination programs for influenza as well as COVID-19.

IDSA urges CMS to reconsider and maintain the COVID-19 HCP vaccination coverage measure to ensure the national health care infrastructure is optimally prepared for current and future infectious disease threats.

OPPS drug policies

340B payments

CMS has proposed to accelerate the recoupment of past overpayments tied to the 340B drug payment litigation by increasing the annual reduction in the OPPS conversion factor from 0.5% to 2%, thereby completing the $7.8 billion offset in six years rather than the previously planned 16-year period. **While IDSA supports the efforts to resolve outstanding financial obligations in a manner consistent with statutory budget neutrality requirements and court orders, we are concerned about the magnitude and pace of the proposed reduction on non-drug service payments, including its impact on health care systems that provide critical infectious diseases therapies and outpatient services.** Given ongoing resource constraints and the mounting pressures on outpatient care infrastructure, particularly for hospitals serving high-risk, complex or underserved patient populations, such an abrupt increase in the offset may jeopardize operational stability, staffing and patient access to essential infectious diseases care.

We urge CMS to carefully weigh the trade-offs of a faster recoupment period and consider whether a more gradual approach, such as the original 0.5% reduction, might better maintain the integrity of care delivery while still achieving the agency's mandated financial objectives. Should CMS proceed with the accelerated 2% annual reduction or the even steeper alternative, we recommend robust monitoring for any unintended consequences and consideration of flexibilities or targeted supports for safety-net and teaching hospitals that may be disproportionately affected. It is imperative that efforts to restore payment equilibrium do not inadvertently undermine care for vulnerable beneficiaries with complex infectious diseases.

Medicare Part B drugs without a Medicaid National Drug Rebate Agreement (NDRA)

IDSA recognizes and supports the proposal to withhold Medicare payment for Part B drugs if manufacturers or labelers fail to promptly enter into a Medicaid NDRA. This enforcement mechanism is an important tool for maintaining the integrity of federal payment programs and ensuring manufacturers fulfill their statutory obligations to participate in the Medicaid Drug Rebate Program, which offsets state and federal health care costs and avoids duplicative discounts.

While the policy does not apply to vaccines, IDSA would like to take this opportunity to highlight ongoing challenges with the current Medicare vaccine reimbursement model. Many routinely recommended adult vaccines, including influenza and other non-COVID vaccines, are covered under Medicare Part D, not Part B. This arrangement restricts physicians' ability to administer these vaccines directly in outpatient settings due to logistical and reimbursement hurdles. The system creates confusion and barriers for both providers and patients, undermining timely immunization for vulnerable older adults. **IDSA strongly urges CMS to consider reforms to the Medicare vaccine payment structure that would facilitate provider-based vaccine administration and improve patient access across all recommended immunizations.**

However, IDSA is concerned about the potential for sudden interruptions in patient access to critical medications, particularly those therapies used to treat serious and complex infectious diseases, if a manufacturer's NDRA status is unresolved. Loss of payment could disrupt the supply and delivery of essential drugs, leading to negative consequences for vulnerable patient populations who already face limited therapeutic options. For this reason, IDSA urges CMS to implement this policy with careful attention to patient protections. We recommend that CMS provide robust advance notification to manufacturers, as well as clear and transparent communication to providers and beneficiaries, regarding affected products and consider reasonable exceptions or transitional arrangements to ensure that patient care is not jeopardized.

Medicare OPPS drug acquisition cost survey

IDSA recognizes that the initiative to conduct a mandatory drug acquisition cost survey, prompted by both statutory requirements and recent executive order directives, aims to improve the accuracy and transparency of Medicare payments for drugs and biologicals, including specified covered outpatient drugs, by collecting real-world hospital purchase cost data on a comprehensive basis.

IDSA generally supports efforts to ensure that Medicare payment rates for outpatient drugs are evidence-based and grounded in actual acquisition costs, as this can enhance payment equity and fiscal stewardship while minimizing inappropriate reimbursement variation across settings. **However, we note that infectious diseases clinicians and their patients rely on continued hospital access to a broad array of complex, sometimes high-cost antimicrobial agents and biological therapies. It is therefore essential that the survey methodology captures all relevant costs, including discounts, rebates, 340B program participation and acquisition costs for specialty drugs used in infectious diseases care, and that results are analyzed with recognition of the unique acquisition arrangements and patient populations served by safety-net and teaching hospitals.**

IDSA urges CMS to carefully balance the need for data completeness and validity against the reporting burden and operational realities faced by hospitals. Mandatory participation may be necessary to achieve a representative and reliable dataset, as non-response could introduce bias and undermine the validity of subsequent payment policy adjustments. However, CMS should provide clear guidance, adequate preparation time, robust technical support and accommodations for small, rural or resource-limited hospitals to ensure compliance does not disrupt patient care or impose undue administrative strain. In addition, if CMS adopts a mandatory survey, the agency should transparently communicate how non-response will be interpreted and ensure hospitals have a clear opportunity to address data discrepancies before results inform payment reforms.

Conclusion

IDSA appreciates the opportunity to provide feedback on the CY 2026 Hospital OPPS and ASC Proposed Rule. We urge CMS to implement payment and policy reforms that sustain access to high-quality infectious diseases care and support the unique needs of both patients and providers. As the health care landscape continues to evolve, it is essential that regulatory updates promote care equity, protect vulnerable populations and advance public health goals. IDSA looks forward to continued collaboration with CMS to achieve these shared priorities. If you have any questions or if we may be of any assistance to you, please do not hesitate to contact Yasmin Rafiq, IDSA's regulatory and reimbursement policy manager, at yrafiq@idsociety.org.

Sincerely,

Tina Tan, MD, FIDSA, FPIDS, FAAP

President

Infectious Diseases Society of America